# Learning From Our Experiences:

## A Review of Selected Country Programs June 2002 to December 2003

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**ACRONYMS**

**AOP:** Annual Operating Plan
**APROFAM**: Asociación Pro Bienestar de La Familia (Association for the Well-Being of the Family, Guatemala)
**BPP:** Business Planning Program
**CMAC:** Council Multi-Sectoral AIDS Committees
**CORE**: Cost Revenue Analysis Tool
**EPHS/F:** Essential Public Health Services/Functions
**FPMD:** Family Planning Management Development
**GOT:** Government of Tanzania
**HRM:** Human Resource Management
**KIX:** Knowledge and Information Exchange Database
**M&E:** Monitoring and Evaluation
**M&L:** Management and Leadership
**MAQ:** Maximizing Access and Quality Initiative
**MIS:** Management Information System
**MOH:** Ministry of Health
**MOST:** Management and Organizational Sustainability Tool
**MOU:** Memoranda of Understanding
**MSH:** Management Sciences for Health
**NGO:** Non-Governmental Organization
**NPHCDA:** Nigeria National Primary Health Development Agency
**PI:** Performance Improvement
**PPI:** Plan for Performance Improvement
**PPP:** Public Private Partnership
**PRISM :** Pour Renforcer les Interventions en Santé Reproductive
**PROCOSI:** Programa de Coordinación en Salud Integral
**PY:** Program Year

PY 1 September 2000 – June 2001
PY 2 July 2001 – June 2002
PY 3 July 2002 – June 2003
PY 4 July 2003 – June 2004
PY 5 July 2004 – June 2005

**RDP:** Rural Development Program
**RFE:** Rapid Funding Envelope
**SAR:** Semi-Annual Report
**SILAIS:** Administrative division at the departmental level of the Ministry of Health
**SWOT:** Strengths, Weaknesses, Opportunities and Threats
**TA:** Technical Assistance
**TACAIDS:** Tanzania Commission for AIDS
**TB DOTS:** Tuberculosis Directly Observed Treatment, Short-course
**USAID:** United States Agency for International Development
**VCT:** Voluntary Counseling and Testing
**WCA:** Workgroup Climate Assessment
**WP:** Workplan

## EXECUTIVE SUMMARY

The Management and Leadership Program (M&L) has developed broad experience over the past four years in strengthening the management and leadership capacity of national ministries of health, decentralized health services at various levels of government, and international and local non-governmental organizations (NGOs). Using data gathered from M&L's Monitoring and Evaluation system and other key documents, a review was carried out of eighteen of M&L's field programs that were implemented between July 2002 and December 2003. The purpose of the review is:

- To provide an overall representation or macro-level view of M&L's work in improving leadership, management, and sustainability of organizations and programs
- To offer evidence of M&L's success or failure in helping field programs achieve their performance objectives
- To provide information to guide future M&L technical assistance

This report is the first in a two-part series. It covers eighteen M&L programs implemented during the period July 2002 to December 2003, corresponding to M&L's Program Year (PY) 3 and the first half of PY4. The second part of the series will be completed by June 2005 and will cover the second half of PY4 and PY5.

**The programs included in this review are**:

1. Bolivia Business Planning Program (BPP)
2. Bolivia COMBASE
3. Bolivia CORE/CHEMONICS
4. Bolivia PROSALUD
5. Brazil HIV/AIDS NGOs
6. Brazil TB DOTS
7. Brazil VCT
8. Egypt Ministry of Health (MOH)
9. Guatemala APROFAM
10. Guinea Ministry of Health (MOH)
11. Honduras ASHONPLAFA
12. Indonesia Ministry of Health (MOH)
13. Nicaragua PROFAMILIA
14. Nicaragua Ministry of Health (MOH)
15. Nigeria National Primary Health Development Agency (NPHCDA)
16. Peru MANUELA RAMOS
17. Tanzania PUBLIC PRIVATE PARTNERSHIPS (PPP)
18. Tanzania TACAIDS

**BACKGROUND:**

Beginning in June 2002, M&L's interventions in the field have been monitored on a systematic basis through the use of a standardized data collection system of planning, monitoring, and evaluation. At the beginning of each program, M&L managers develop a Plan for Performance Improvement (PPI)[1] and, jointly with a designated Monitoring and Evaluation (M&E) Unit staff person assigned as a liaison, a monitoring and evaluation plan tailored to each client's needs. The PPI and M&E plan are entered into M&L's electronic database, Knowledge and Information Exchange (KIX), which also tracks the progress of M&L work plans via semi-annual reports and stores information on M&L tools and indicators. While the system described above collects evidence in summary from across all field-based programs, the M&E Unit also conducts a number of in-depth evaluations of selected field-based programs using both qualitative and quantitative methods. Taken together, these components of the M&E system provided information for this Cross Program Review.

**FINDINGS:**

**Characteristics of Client Organizations:**

- **Geographic location:** Twelve of the programs were in Latin America; five were in Africa; and one was in Asia.
- **Organizational type**: There is a fairly even breakdown of programs by type, with 44% in the non-governmental sector and 50% in the public sector. M&L is also working with one parastatal[2] in Nigeria.
- **Setting**: 38% of interventions were implemented in hospitals and hospital clinics; 28% in communities and community clinics; 17% at the central level of ministries of health; 6% at the municipal level; and 11% targeted to all levels of a ministry of health.
- **Client's geographic coverage**: 66% of M&L's clients have national coverage, whether as national health ministries or as NGOs whose networks have national penetration. Reflecting a recent focus on directly strengthening management and leadership at the local level, six programs focused on regional and municipal governments.
- **Previous technical assistance from MSH**: 78% had received previous technical assistance from MSH either during the Family Planning Management Development (FPMD) Program or during the early years of the Management and Leadership Program.
- **Duration:** Four out of the eighteen programs have had four years of assistance from M&L at the time of this review; four have had three years; three have had two years; and seven programs were implemented over one year only.
- **Cost:** The largest program is Indonesia MOH, with $4.2 million in expenditures over three years as of December 2003; the smallest completed program was Peru/Manuela Ramos at $ 50,772.

**Challenges:** The predominant theme that cuts across the public sector programs during this time period is the challenge of decentralization. For NGO programs it is the withdrawal of funding by

[1] The Plan for Performance Improvement (PPI) is a planning tool that facilitates the use of the PI process with M&L clients and provides the basis for developing a client-focused monitoring and evaluation plan

[2] A government-owned company or enterprise

large international donors and an increased need to develop other sources of income to assure sustainability.

**Key Findings:**

- Progress has been made on a number of fronts in helping clients to achieve their performance objectives. Out of the eighteen projects reviewed, only the Tanzania Public-Private Partnership program was unable to achieve its performance objectives
- Programs vary in how well they are able to demonstrate the impact of management and leadership strengthening on health services. The demonstration of impact at the service delivery level is a function of whether interventions are focused at the district level and below (as opposed to the regional or provincial level and above) and the length of time for which M&L has funding (core or field support) to work with the client organization.
- M&L's ability to show results, especially in terms of services, depends on the clients' own M&E systems, specifically their ability to provide accurate baseline data and end-of-project data.
- The financial sustainability of NGOs can be improved, but care needs to be taken to ensure that services for populations in need are not compromised in the process.
- Technical assistance in management development should be accompanied by parallel assistance in leadership development, or at least change management, as a means to assure that system changes are fully integrated and institutionalized into an organization's standard operations at all levels of the organization (i.e., headquarters, regions or branches, and clinics).
- Similarly, technical assistance in leadership development should be accompanied by parallel assistance in key management areas, especially information and logistics management and quality assurance. Such assistance could be provided by M&L itself, by an MSH bilateral with which M&L is collaborating, or another CA working with the client organization. In the case of an MSH bilateral or another CA, a concrete agreement to collaborate closely and share information is vital.
- Sustainability of programs in the public sector may require intervening at more than one level.
- M&L's ability to track organizational performance over the long-term, following the completion of a project, is limited if Mission funding or core funds from USAID/W are not available. This is especially the case in instances where USAID has withdrawn population funding.
- M&L should align its collaboration with other Cooperating Agencies (CAs) in the field to complement CA assistance in service delivery or management of the changing environment. That being said, M&L should ensure that adequate funding is available to complete all proposed work, and that the collaborating CA will be working with the client through the entire period of proposed assistance. During M&L's collaboration with Chemonics in Bolivia, Chemonics finished activities before M&L's program ended, and there was no longer an on-site presence to support the municipal health managers.
- M&L has experience with both the public sector and NGOs that can be leveraged in the future to build capacity for scaling up services. The twin themes of decentralization for public sector programs and sustainability for NGOs are extremely timely and will be especially useful as M&L continues to strengthen the management and leadership of HIV/AIDS, reproductive health, and child health programs in Africa and other regions.

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## 1. INTRODUCTION

The Management and Leadership Program (M&L) has developed broad experience over the past four years in strengthening the management and leadership capacity of national ministries of health, decentralized health services at various levels of government, and international and local non-governmental organizations (NGOs). Building on the foundation of the Family Planning Management Training Program and the Family Planning Management Development Programs, M&L provides technical assistance (TA) to clients involved in reproductive health care, family planning, maternal and child health, AIDS-related services, and treatment for infectious diseases. Interventions range in size and scope from assistance to small NGO programs in Latin America to large multi-faceted initiatives across all levels of Ministries of Health in Central America, Africa, and Asia. The breadth of M&L's experience provides a unique opportunity to look across a variety of field-based programs and to compare commonalities and differences in M&L's approach to facilitating clients' achievements of their performance objectives.

This report is the first in a two-part series. It covers eighteen M&L programs implemented during the period July 2002 to December 2003, corresponding to M&L's Program Year (PY) 3 and the first half of PY4. The second part of the series will be completed by June 2005 and will cover the second half of PY4 and PY5.

## 2. BACKGROUND

Beginning in June 2002, M&L's interventions in the field have been monitored on a systematic basis through the use of a standardized data collection system of planning, monitoring and evaluation. At the beginning of each program, M&L managers develop a Plan for Performance Improvement (PPI) and, jointly with a designated Monitoring and Evaluation (M&E) Unit staff person assigned as a liaison, a monitoring and evaluation plan tailored to each client's needs is developed. The PPI and M&E plan are entered into M&L's electronic database, KIX (Knowledge and Information Exchange), which also tracks the progress of M&L work plans via semi-annual reports and stores information on M&L tools and indicators. While the system described above collects evidence in summary from across all field-based programs, the M&E Unit also conducts a number of in-depth evaluations of selected field-based programs using both qualitative and quantitative methods.

Taken together, these components of the M&E system provide information that can assist M&L in:

- Demonstrating progress in strengthening organizational management and leadership; and
- Identifying the processes by which improvements in management and leadership contribute to improved access and quality of service delivery

At the same time, the work of carrying out a cross-program review allowed us to look critically at M&L's current data collection system and to determine how well it captures and documents M&L interventions and the outcomes of those interventions for clients. A companion report on the review of M&L's monitoring and evaluation system is available under separate cover.

## 3. METHODOLOGY

### 3.1. Period of review

To be included in this review, programs had to 1) be field-based (as opposed to Boston-based work, such as publications or participation in global initiatives like the Maximizing Access and Quality [MAQ] Initiative), 2) have conducted at least some activities in PY3 (after June 2002) and 3) have either ended or completed most of the planned activities by December 2003. Some programs were completed in this time frame, some were forced by circumstances to end early, and some are still ongoing. It should be remembered that during this period a true snapshot of M&L programs would have included several others that were in the beginning stages. Therefore any generalizations and conclusions are limited by the process of selecting programs that had already shown results.

The programs included in this review are:

1. Bolivia Business Planning Program (BPP)
2. Bolivia COMBASE
3. Bolivia CORE/CHEMONICS
4. Bolivia PROSALUD
5. Brazil HIV/AIDS NGOs
6. Brazil TB DOTS
7. Brazil VCT
8. Egypt Ministry of Health (MOH)
9. Guatemala APROFAM
10. Guinea Ministry of Health (MOH)
11. Honduras ASHONPLAFA
12. Indonesia Ministry of Health (MOH)
13. Nicaragua PROFAMILIA
14. Nicaragua Ministry of Health (MOH)
15. Nigeria National Primary Health Development Agency (NPHCDA)
16. Peru MANUELA RAMOS
17. Tanzania PUBLIC PRIVATE PARTNERSHIPS (PPP)
18. Tanzania TACAIDS

### 3.2. Sources of Information

All components of the M&E system as well as ancillary documents were consulted in collecting data for the review. These included:

- PY3 and PY4 Work plans and Semi-Annual Reports in KIX
- PPIs and M&E plans in KIX
- PPIs and M&E plans centrally filed on the M&L's shared drives (prior to the introduction of KIX)
- Evaluation Notes (4 page summaries of in-depth evaluations prepared by the M&E Unit)
- Reports of in-depth evaluations
- Trip reports
- Financial reports on program expenditures prepared monthly by the M&L Program

Data from the sources listed above were extracted and entered into program capture forms (see Appendix I for individual program capture forms). When fields could not be completed from the information available, M&L program managers were interviewed by e-mail, over the phone, or in person. Performance objectives and results were drawn preferentially from the M&E plans. When no M&E plan was available, they were drawn from the work plan and Semi-Annual Reports.

### 3.3. Study Questions

The following questions are addressed in this study:

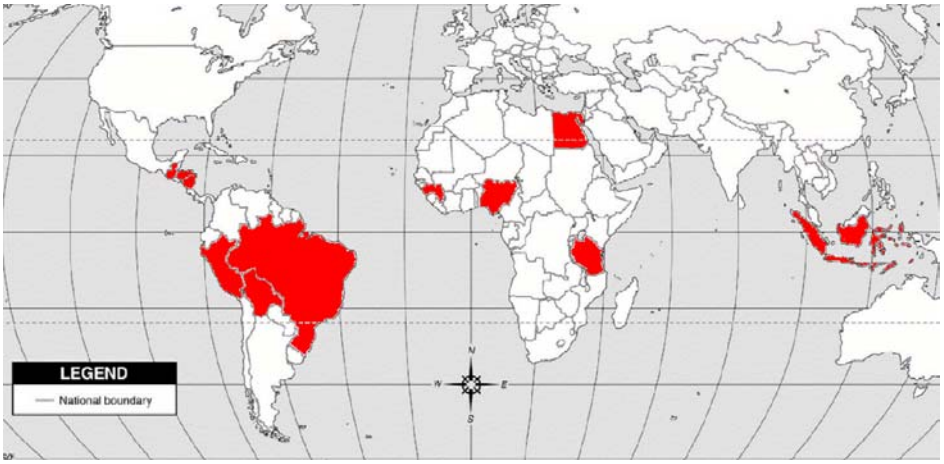
1. What are the types of organizations or clients (e.g. NGO, government, private, etc.) with which the M&L Program is working?
2. In what type of setting are the organizations operating (community, hospital, health center, etc.)? At what level are they operating (national, provincial, district) and what is their geographic coverage?
3. What was the duration of M&L involvement in each program and what is its relation to the client's achievement of its performance objectives?
4. How many programs had previously received technical assistance from MSH?
5. What types of challenges or problems were identified by these organizations?
6. What types of M&L interventions were selected to address the identified challenges?
7. What was the cost of M&L involvement in each program since its inception through December 2003?
8. What were the performance results? Did the organizations achieve their performance objectives?
9. What other factors were responsible for success or failure to achieve performance objectives?

The purpose of this analysis of field program-based programs is threefold:

1. To provide an overall representation, or macro-level view, of M&L's work in the areas of leadership development, improvement of management systems, and improving sustainability;
2. To offer evidence of M&L's success or failure in helping field programs achieve their performance objectives; and
3. To provide information to guide future M&L technical assistance.

## 4. FINDINGS

### 4.1. Geographic location of the programs




Bolivia
Brazil
Egypt
Guatemala
Guinea
Honduras
Indonesia
Nicaragua
Nigeria
Peru
Tanzania

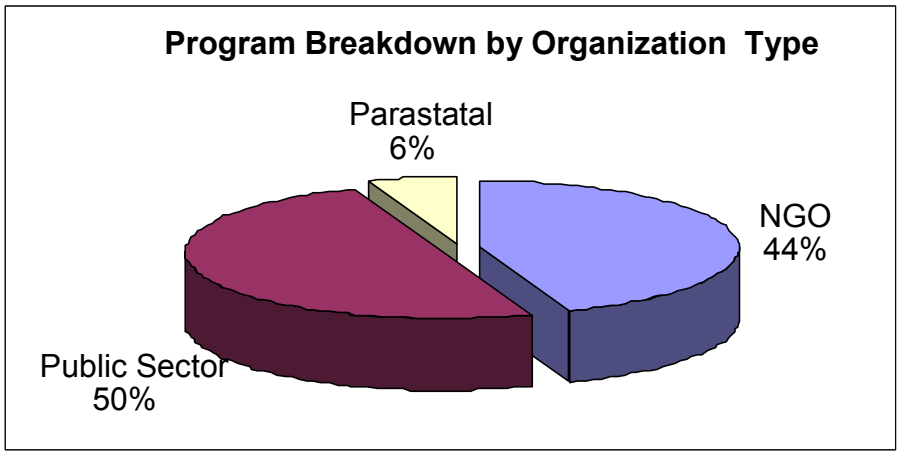
The map above provides an overview of the geographic location of the eighteen programs in the study. Latin America is heavily represented with 12 programs, while Africa has five, and Asia one. Of the twelve programs in Latin America, only three are continuing into PY5: Bolivia PROSALUD, Bolivia COMBASE, and Nicaragua MOH (the latter in a different form than the three year leadership development program that is the focus of this review). In Africa, Nigeria NPHCDA and Tanzania TACAIDS are continuing, and the program in Indonesia will run until December 2004. These six programs will continue to be the subject of the cross program review in PY5.

### 4.2. Program breakdown by organization type

**Table 1. Program Breakdown by Organization Type**

| NGO | Public Sector | Parastatal |
|---|---|---|
| Bolivia BPP | Guinea MOH | Nigeria NPHCDA |
| Peru MANUELA RAMOS | Egypt MOH | |
| Bolivia PROSALUD | Bolivia CORE/CHEMONICS | |
| Bolivia COMBASE | Brazil TB DOTS | |
| Brazil HIV/AIDS NGOs | Brazil VCT | |
| Guatemala APROFAM | Indonesia MOH | |
| Honduras ASHONPLAFA | Nicaragua MOH | |
| Nicaragua PROFAMILIA | Tanzania PPP | |
| | Tanzania TACAIDs | |

**Chart 1. Program Breakdown by Organization Type**



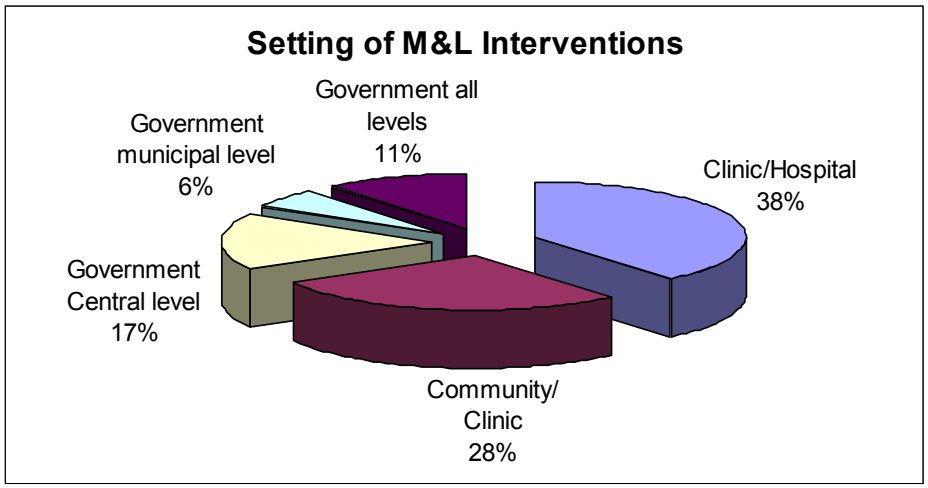

There is a fairly even breakdown of programs by organization type with 44% in the non-governmental sector and 56% in the public sector (the latter includes the Nigerian parastatal NPHCDA). The category of NGO covers a variety of organizations from the small incipient HIV/AIDS NGOs in Brazil to large NGOs like PROFAMILIA in Nicaragua and NGO networks such as PROCOSI/Bolivia. Similarly, public sector organizations range from small municipalities in Bolivia (CORE/CHEMONICS) to all levels of a pubic health sector (Indonesia and Nicaragua MOH)

### 4.3. Setting of M&L Interventions

**Table 2. Setting of M&L Interventions**

| Clinic/Hospital | Community/Clinic | Govt. Central level | Govt. municipal level | Govt. all levels |
|---|---|---|---|---|
| Egypt MOH | Bolivia PROCOSI | Guinea MOH (Central & Regional) | Bolivia CORE/CHEMONICS | Indonesia MOH |
| Bolivia PROSALUD | Peru MANUELA RAMOS | Tanzania PPP | | Nicaragua MOH |
| Bolivia COMBASE | Brazil HIV/AIDS NGOs | Tanzania TACAIDs | | |
| Brazil VCT | Guatemala APROFAM | | | |
| Brazil TB DOTS | Nigeria NPHCDA | | | |
| Honduras ASHONPLAFA | | | | |
| Nicaragua PROFAMILIA | | | | |

**Chart 2. Setting of M&L Interventions**



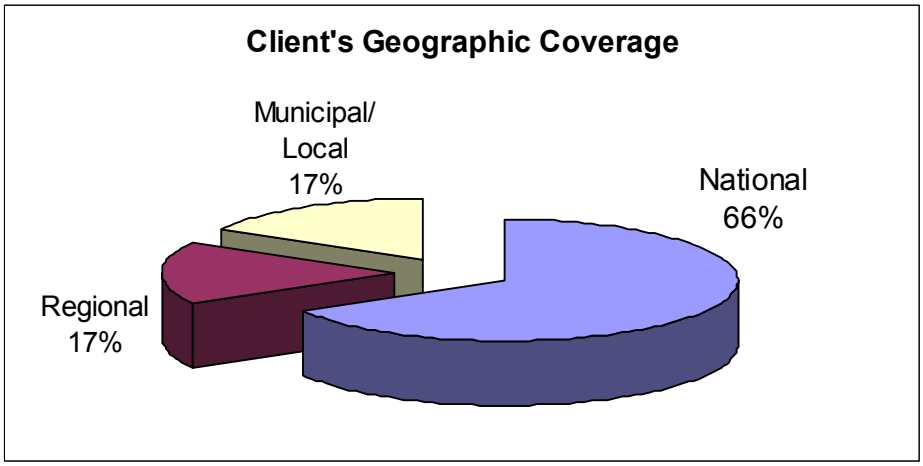

The chart above illustrates M&L's experience in providing technical assistance to clients who operate in a variety of health settings. In Brazil, M&L helped integrate TB and voluntary counseling and testing (VCT) services into family health clinics. The Egypt MOH Leading for Performance Improvement Program focused on improving service delivery at the district and clinic levels within a single Governorate. In Guinea the Leadership Development Program invested first in changing practices and behaviors at the central and regional levels of the health system in order to support future leadership development at the lower levels. In Indonesia, M&L works at all levels of government to implement policy changes, improve health planning and financing, and strengthen management of essential drugs. By strengthening management systems, M&L assisted NGOs in Bolivia, Honduras, Guatemala, and Nicaragua to better manage their networks of clinics and hospitals.

### 4.4. Client's Geographic coverage

**Table 3. Client's Geographic Coverage**

| National | Regional | Municipal/Local |
|---|---|---|
| Bolivia BPP | Brazil HIV/AIDS NGOs | Bolivia CORE/CHEMONICS |
| Peru MANUELA RAMOS | Brazil VCT | Bolivia COMBASE |
| Bolivia PROSALUD | Egypt MOH | Brazil TB DOTS |
| Guatemala APROFAM | | |
| Honduras ASHONPLAFA | | |
| Nicaragua PROFAMILIA | | |
| Nigeria NPHCDA | | |
| Tanzania TACAIDs | | |
| Guinea MOH | | |
| Indonesia MOH | | |
| Nicaragua MOH | | |
| Tanzania PPP | | |

**Chart 3. Client's Geographic Coverage**

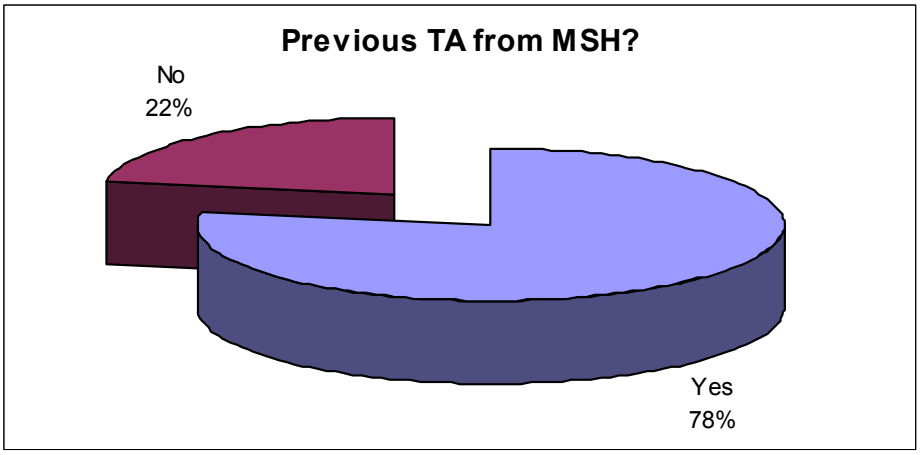



The chart above shows that 66% of M&L's clients have national coverage, whether as national health ministries or as NGOs whose networks have national penetration. Six programs focused on government at regional or municipal levels to the exclusion of national levels (Brazil VCT, Brazil HIV/AIDS NGOs, Egypt MOH, Bolivia CORE/Chemonics, Bolivia Combase and Brazil TB DOTS).

### 4.5. Previous Technical Assistance from MSH

As shown in the chart below, 78% of the programs had received technical assistance from MSH in the past whether just prior to the intervention (Bolivia COMBASE), in FPMD II (Bolivia PROCOSI, Nicaragua PROFAMILIA, Bolivia PROSALUD, Honduras ASHONPLAFA, Peru MANUELA RAMOS, and Tanzania PPP) or through an MSH Bilateral Program (Guatemala APROFAM, Nicaragua MOH, and Guinea MOH)

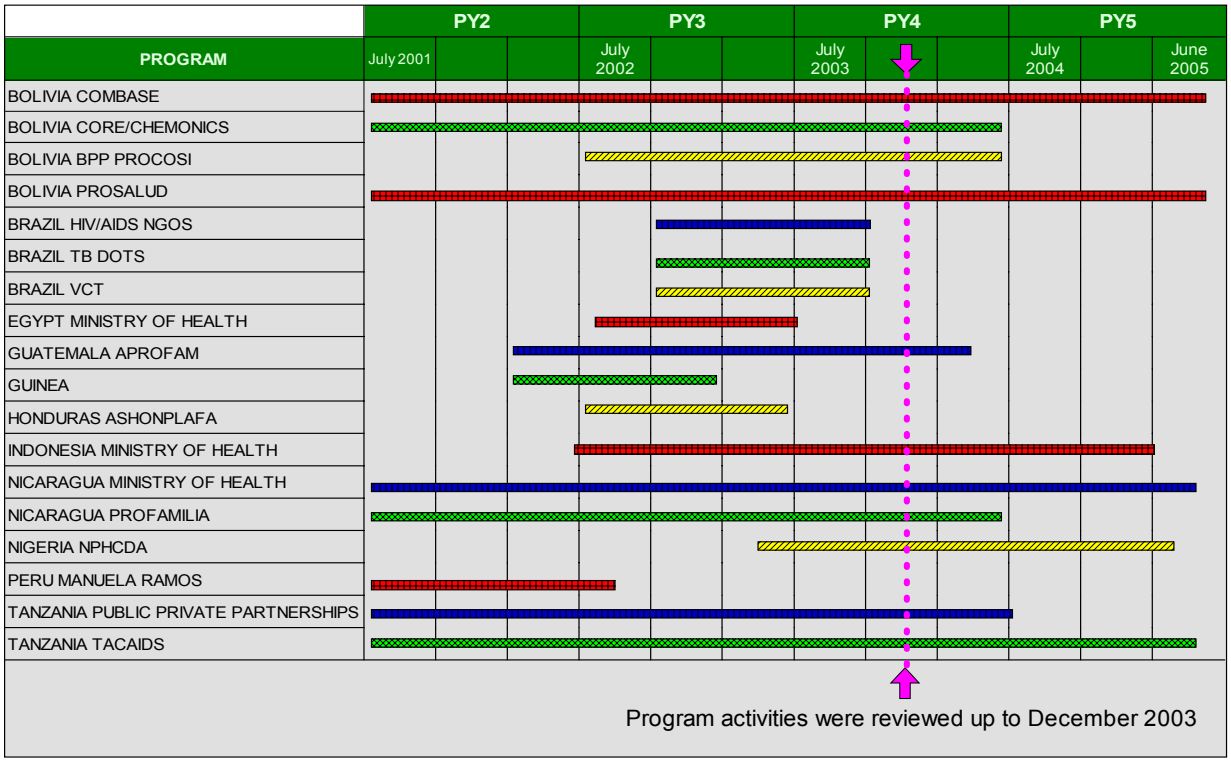
**Chart 4. Previous technical assistance from MSH**



### 4.6. The duration of M&L involvement in each program

The chart below illustrates the duration of M&L involvement in each of the programs. The dotted pink line indicates the length of time the program had been in operation as of December 2003, the last date for which activities were considered for this review.

**Chart 5. Duration of Programs**




The M&L projects selected for the Cross Program Review had all conducted at least some activities in PY3 (after June 2002) and had ended or completed most of the planned activities by December 2003 (mid PY4).

Four out of the eighteen programs have four years duration; four have three years duration; three have two years duration; and seven were short-term (one year). Nigeria NPHCDA had only been in operation for 9 months at the time of this review. The short-term nature of programs is related to two issues: 1) the availability of Mission funding (e.g., Honduras, Peru), and 2) USAID/W's support for the use of core funds to implement field-based activities (e.g., Egypt, Guinea, PROCOSI/BPP). Core funds are appropriate for "research and development" activities, such as the pilot Leadership Development Programs in Egypt and Guinea. However, Cooperating Agencies can not use core funds to implement longer-term programs. It is expected that the use of core funds to develop, implement, and refine a new program will leverage mission field support funds for a program's longer-term implementation.

A number of factors affect the length of time available for programs to be implemented and to demonstrate results. M&L's participatory processes and commitment to sustainability require time to gain stakeholder involvement. Implementation of the necessary changes consumes the

greater part of the program cycle so that the ability to show results, especially in terms of improvements in service delivery, may be limited. Other factors, such as the opportunity for the M&E Unit to follow up programs six months or more after implementation, can be affected by donor constraints (HIV/AIDS and TB programs cannot be evaluated using core Population funds), or by a lack of awareness on the part of the client organizations that the program requires baseline and follow-up measures to determine program success. Long intervention time is not a guarantee of success, as it may be an indication that there are barriers to implementation. Such was the case of Tanzania PPP, which was finally suspended, and Bolivia PROSALUD, where key financial personnel are resisting change.

### 4.7. Public Sector Challenges and Interventions

The predominant theme that cuts across the public sector programs during this time period is the challenge of decentralization in all of its varied forms: deconcentration to lower levels of a national ministry structure; delegation to semi-autonomous bodies such as hospitals or community health boards; devolution to separate local governments; and privatization in partnership with NGOs and for-profit organizations to extend the reach of the public sector.[3]

**Table 4. Challenges and Interventions in the Ten Public Sector Programs**

| NAME OF PROGRAM | CHALLENGE | INTERVENTION |
|---|---|---|
| Bolivia CORE/CHEM-ONICS | Strengthen financial management capacity of selected municipalities | Adapt the Cost Revenue Analysis Tool (CORE)[4] to national universal health insurance program for use at municipal level |
| Brazil TB DOTS | Integrate a TB DOTS program in two clinics in a selected municipality into Brazil's primary care system of family health teams | Develop guidelines and norms, design systems, and train DOTS managers and health care providers in provision of TB DOTS services |
| Brazil VCT | Decentralize quality VCT services to a micro-region in the state of Ceará and thereby increase access to testing, especially for vulnerable populations | Develop guidelines and norms for centers and for testing and lab reporting, design systems, and train staff in VCT services |
| Egypt MOH | Improve quality of and access to health services in 3 districts and 7 health facilities clinics in three districts of Aswan Governorate | Implement Leading for Performance Improvement Program with bi-monthly district skill-building meetings, and PI programs for clinic staff. |
| Guinea MOH | Improve central level and regional | Implement Leadership Development |

[7] Decentralizing Health and Family Planning Services. *The Manager*. Management Sciences for Health, 2001.
[4] The Cost Revenue Analysis Tool (CORE) is a spreadsheet that analyzes individual services and overall clinic performance using existing and projected cost, revenue, and service information. The tool calculates a number of indicators that can be used by managers, including unit costs, level of cost recovery (by service and overall), staff utilization, and labor costs.

| NAME OF PROGRAM | CHALLENGE | INTERVENTION |
|---|---|---|
| | team leadership and implementation of the decentralization process | Program for central level MOH staff and regional level health officials in 2 regions |
| Indonesia MOH | Assist districts with health planning and financing, improve availability of drugs and contraceptives, and improve community-based surveillance of infectious disease outbreaks | 1. Develop a matrix of essential health functions and minimum service standards<br>2. Assist districts with participatory planning and budgeting<br>3. Provide TA and guidelines to vertical programs to improve drug availability<br>4. Provide TA to provinces and districts for surveillance of infectious disease outbreaks |
| Nicaragua MOH | Prepare managers and health workers at the municipal level to assume greater responsibilities and new roles within the context of health sector reform and decentralization. The primary challenge identified within this context was low motivation among health workers | 1. Baseline and follow-up measurement of organizational climate<br>2. Deliver six modules on leadership development for municipal and SILAIS directors and facilitators<br>3. Municipal facilitators replicate program to the remaining staff in the participating municipalities.<br>4. Municipalities implement action plans to improve climate |
| Nigeria NPHCDA | Put management systems in place that can support a network of 200 newly constructed health centers, with a focus on strategic and operational planning, service statistics gathering and analysis, financial record keeping and reporting and human resources planning and evaluation | 1. Participatory Management Assessment<br>2. Strategic Planning<br>3. Service Statistics Pilot Program<br>4. Financial System Development<br>5. Human Resources System Development |
| Tanzania TACAIDS | Improve Tanzania's ability to coordinate multi-sectoral partnerships and manage the rapid scale-up of the national response to the HIV/AIDS epidemic by strengthening the institutional capacity of the National HIV/AIDS Commission (TACAIDS) | 1. District Capacity Assessments<br>2. Civil Society Fund for the World Bank's Multi-country AIDS Program<br>3. Rapid Funding Envelope<br>4. TACAIDS Commission retreat<br>5. District strategy support<br>6. Response to Global Fund for AIDS, TB, and Malaria<br>7. TACAIDS Secretariat directors orientation, teambuilding and strategic planning |

| NAME OF PROGRAM | CHALLENGE | INTERVENTION |
|---|---|---|
| Tanzania PPP | Enlarge the group of health service providers who will implement the essential health package, and create a favorable environment for the formation of partnerships between public and private sector institutions and groups at the district, regional, and central levels. | 1. District Rapid Assessment of PPPs<br>2. Develop a strategic plan for public private partnerships<br>3. Design a package of interventions to analyze and revise existing contractual mechanisms between governmental and non-governmental institutions<br>4. Tools and training which can be used by districts and municipalities to identify potential local partners |

All of the public sector programs developed interventions to strengthen the underlying factors that need to come together to make decentralization work. These include:

- Strengthening the capacity of municipalities and districts to plan based on their own health indicators and to assume responsibility for collecting and analyzing financial information (Bolivia CORE/CHEMONICS, Indonesia MOH)
- Coordinating partnerships with the private sector, parastatals, and with other sectors of government to scale up services which the public sector cannot offer alone (Nigeria NPHCDA, Tanzania PPP, Tanzania TACAIDS)
- Changing the mindset of central level health managers from a command and control model to one that manages by inspiration, aligning and mobilizing lower level teams towards common goals (Guinea MOH, Nicaragua MOH)
- Changing the mindset of local managers and health care providers on the front lines to take initiative and to gain confidence in their own abilities to address service delivery challenges and achieve results (Egypt MOH, Nicaragua MOH)
- Integrating vertical programs into primary care services at the local level (Brazil VCT, Brazil TB DOTS)

In three programs (Indonesia MOH, Nicaragua MOH, and Tanzania TACAIDS), interventions were carried out over a longer time frame and were designed for varying levels of the public health system. Most commonly, programs had only short term funding and had to focus resources either on the central or decentralized levels. Showing results at the service delivery level is difficult when interventions focus only on the central level (Guinea MOH). When interventions are targeted directly to clinics or district levels, sustainability may be compromised if support at the upper levels for change is absent.

### 4.8. Challenges and Interventions in Eight NGO Programs

As countries all over the world have grappled with how best to decentralize health care to increase service delivery effectiveness and improve the efficiency of resource utilization, a parallel growth has taken place in the role that NGOs play in partnering with the public sector to expand reproductive health and family planning services. A look across the eight NGO programs in this review confirms the challenge of capacity building for NGOs in various stages of maturity

from the fledgling HIV/AIDS NGOs in the Amazon region of Brazil to experienced and established NGOs such as Guatemala APROFAM and Nicaragua PROFAMILIA

The table below summarizes the challenges and interventions of each of the eight NGO programs.

**Table 5. Challenges and Interventions in Eight NGO Programs**

| NAME OF PROGRAM | CHALLENGE | INTERVENTION |
|---|---|---|
| Bolivia COMBASE | To improve performance in the hospital and clinics (5) in their Christian evangelical network in order to remain financially sustainable | 1. Develop and monitor 2003 annual work planning process<br>2. Develop new Management Information System<br>3. Evaluate administrative, financial & HRM processes<br>4. Build capacity of Board of Directors and Executive Director<br>5. Provide TA in financial sustainability |
| Bolivia PROCOSI Business Planning (BPP) | To enable 8 members of PROCOSI's NGO network to access alternative sources of funding so that they can become financially sustainable in light of reduced USAID funding and legal requirement to offer care to the poor at no cost. | 1. Delivery of a blended-learning program using face-to-face and electronic methodologies to guide participating organizations through six modules to develop a business plan<br>2. Train PROCOSI network to replicate the program with other NGOs |
| Bolivia PROSALUD | To re-engineer management systems and processes in order to strengthen overall financial sustainability after the end of USAID support | 1. Redefine roles, functions and competencies<br>2. Redesign management systems<br>3. Up-date job positions and organizational structure<br>4. Review existing instruments and tools for processes and systems<br>5. Design strategic management control system |
| Brazil HIV/AIDS NGOs | Improve financial sustainability and strengthen overall management of 4 HIV/AIDS NGOs in the poor Northern region of Brazil | 1. Conduct pre- and post-management assessment workshops with each of the four NGOs using MOST<br>2. Conduct workshops in the selected areas for strengthening: re-formulation of by-laws, strategic planning, human resources management, financial management and fundraising. |
| Guatemala APROFAM | To prepare APROFAM for significantly reduced international donor support by generating alternative sources of revenue through its conversion of its Rural Development Program into a social marketing program | 1. Implement management information and supervisory systems<br>2. Train volunteer promoters in sales and marketing<br>3. Implement a variable compensation program for the Rural Development Program (RDP)<br>4. By special request of the client, provide technical assistance in strategic planning and developing a |

| NAME OF PROGRAM | CHALLENGE | INTERVENTION |
|---|---|---|
| | | business plan |
| Honduras ASHONPLAFA | To increase financial sustainability from 30% to 70% by 2007 | 1. Update the strategic plan<br>2. Structure the market management unit with cost structure and pricing policy oriented toward clients<br>3. Establish an information system<br>4. Design and implement an integrated marketing plan.<br>5. Identify indicators for market, sales and competition analysis and monitor distribution channels |
| Nicaragua PROFAMILIA | To strengthen organizational and financial sustainability and leadership at all levels in the context of the loss of USAID funding | 1. Design MIS system including computer programming for MIS modules<br>2. Deliver Leadership Development Program to senior managers from central office and directors of clinics |
| Peru Manuela Ramos | To ensure organizational efficiency and medium term sustainability by identifying and promoting new leaders, introducing a processes for reflection and analysis, establishing a modern governance structure, and programming an image that is consistent with values | 1. Provide technical assistance in applying the Performance Improvement (PI) methodology to identify and address the primary challenges<br>2. Form Performance Improvement teams to define actual and desired performance, analyze the gap and its causes, and submit an intervention proposal |

The principal challenges that all of these NGOs face is the withdrawal of funding by large international donors, the lack of local philanthropy to fill that role, and an increased need to develop other sources of income to guarantee sustainability. Whether by client desire or USAID mission request, management interventions predominate among NGO programs (with the exception of Nicaragua PROFAMILIA and Peru Manuela Ramos, which also addressed leadership). M&L's management interventions have been well field tested and appear fairly standard across these programs. They include improving strategic planning and management information systems and updating financial and Human Resource Management (HRM) systems.

Two programs stand out for their innovation: PROCOSI BPP used blended learning to deliver a modularized program in business planning to help Bolivian NGOs diversify their sources of funding. Guatemala APROFAM developed a social marketing program to sell contraceptives through its Rural Development Program (RDP) in order to enable the NGO to become more efficient and generate higher revenues.

### 4.9. Program Costs

The table below provides a comparison of program expenditures between July 2001 and December of 2003. M&L's financial system tracks expenditures against entire workplans, not individual activities. Some of the interventions were sub-programs of larger work plans and their costs could not be tracked individually (Brazil HIV/NGOs and VCT and Brazil TB DOTS). Although the same was true for Nicaragua MOH, expenditures for the leadership component were broken out in the recent in-depth study by M&L of that program, and they are reported here.

**Table 6. A comparison of program expenditures from inception to December 2003 in US$**

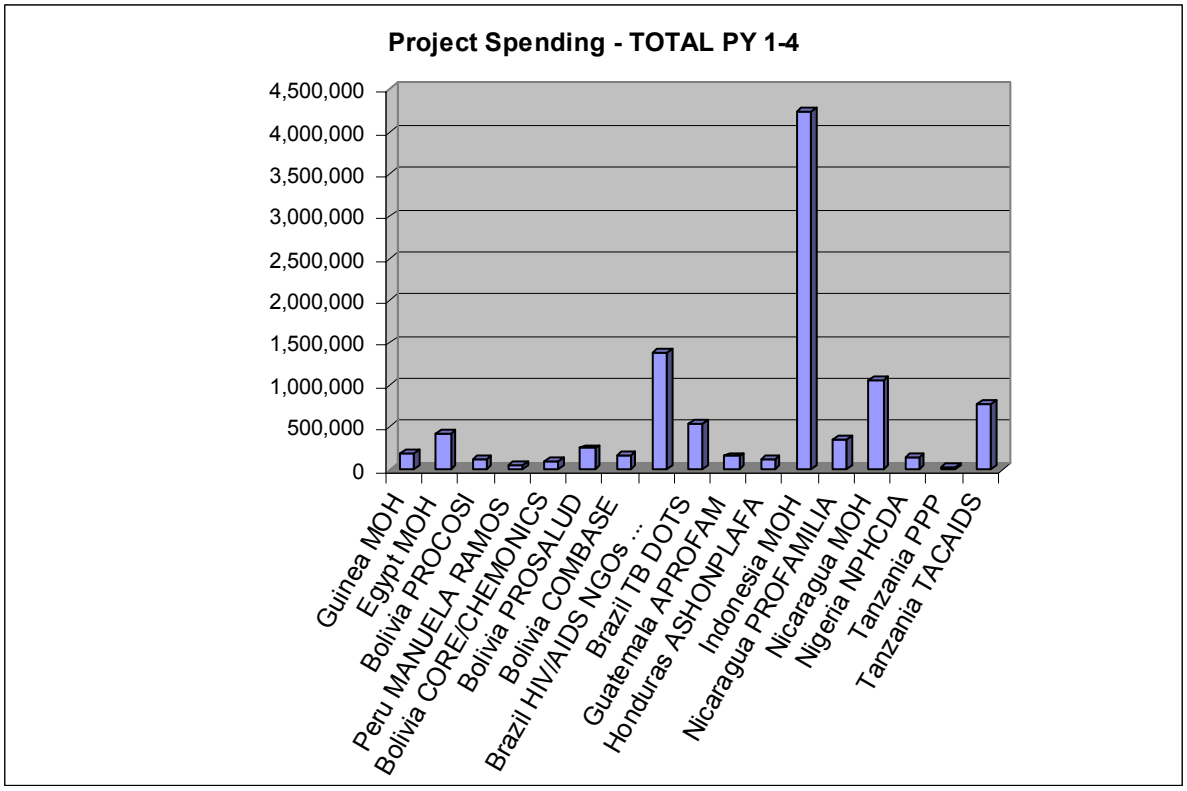
| Program | PY1 | PY2 | PY3 | PY 4 thru 12/03 | Grand Total |
|---|---|---|---|---|---|
| Bolivia PROCOSI | 0 | 0 | $102,888 | $16,302 | $119,190 |
| Bolivia CORE/CHEMONICS | 0 | $32,665 | 44,270 | 12,723 | 89,658 |
| Bolivia PROSALUD | $288 | 59,814 | 106,191 | 82,695 | 248,988 |
| Bolivia COMBASE | 150 | 27,723 | 84,189 | 52,594 | 164,656 |
| Brazil HIV/AIDS NGOs & VCT* | 0 | 0 | 457,525 | 290,242 | *1,391,505 |
| Brazil TB DOTS** | 0 | 0 | 275,844 | 165,476 | ** 537,420 |
| Egypt MOH | 0 | 83,422 | 335,221 | 1,315 | 419,958 |
| Guatemala APROFAM | 0 | 0 | 62,970 | 91,751 | 154,721 |
| Guinea MOH | 0 | 62,276 | 128,195 | 8,162 | 198,633 |
| Honduras ASHONPLAFA | 0 | 39,972 | 72,510 | 524 | 113,006 |
| Indonesia MOH | 0 | 735,224 | 2,043,216 | 1,464,830 | 4,243,270 |
| Nicaragua PROFAMILIA | 0 | 126,198 | 165,695 | 60,960 | 352,853 |
| Nicaragua MOH | 0 | 70,606 | 54,023 | 339,506 | 1,051,136 |
| Nigeria NPHCDA | 0 | 0 | 116,526 | 37,067 | 153,593 |
| Peru MANUELA RAMOS | 17,619 | 21,849 | 11,304 | 0 | 50,772 |
| Tanzania TACAIDS | 0 | 192,588 | 365,530 | 214,324 | 772,442 |
| Tanzania PPP | 0 | 22,906 | 0 | 1,431 | 24,337 |

* Includes other HIV/AIDS activities ** Includes other TB activities

The growth of M&L field programs as a whole is evident from a look across program years. The largest program by several orders of magnitude is Indonesia MOH, which, at $4.2 million in expenditures over three years, is four times as large as the next largest program, Nicaragua MOH, at a little over $1 million over three years. Peru's Manuela Ramos was one of M&L's earliest programs but was limited in scope to only $50,772 due to a decision by the mission to fund another USAID Cooperating Agency (CA). This occurred despite the expressed desire of the NGO for continued and expanded M&L technical assistance. In general, NGO programs have smaller budgets and expenditures than public sector programs.

Chart 7 below provides a comparison of program expenditures at a glance. Please see Appendix II for a breakdown of expenditures by program year and by region.

**Chart 6. Total program expenditures for PY1-PY4 (as of December 2003)**




## 4.10. To what degree did clients in public sector programs achieve their performance objectives?

Performance objectives can be defined for a program at several different points during the program cycle:

- During work planning prior to the program's inception as work plan outcomes and outputs
- During development of the PPI
- During discussions with the program's M&E liaison when work plan outcomes and outputs are refined and indicators are developed for the M&E plan
- Jointly with a country mission which may have criteria of its own for monitoring and evaluation

Not all programs have performance objectives defined in M&E plans. In the early months of PY3 when the M&E system was in its development phase and M&E liaisons were not yet assigned to work with each program from the beginning, performance objectives were often those specified in the work plan. Because the primary purpose of the work plan is to plan and budget for program activities, outcomes tended not to be written in results language but rather in general terms such as strengthened capacity, improved management systems and reengineered management information systems. The question of what measurable changes would result for the client or the population served by the client began to be addressed as the M&L program took on the responsibility for reporting on measurable improvements in services as a result of M&L interventions. This has sometimes meant that programs that began with one general performance objective concerning the strengthening of management and leadership in PY2, could feel the need for reporting on the link to service improvements in PY4.

Table 7 below summarizes the results of M&L interventions for public sector programs. These results are reported against indicators defined in M&E plans.

**Table 7. Results in Ten Public Sector Programs**

| NAME OF PROGRAM | CHALLENGE | RESULTS |
|---|---|---|
| Bolivia CORE/CHEMONICS | Strengthen financial management capacity of selected municipalities | CORE was adapted and applied but not fully implemented at the municipal level when the government of Bolivia changed, for the second time in 1 year, the national insurance program. This required further adaptation of CORE immediately before the program ended. |
| Brazil TB DOTS | Integrate a TB DOTS program in two clinics in a selected municipality into Brazil's primary care system of family health teams | Norms and guidelines were successfully implemented for that period. Three months after the program was implemented, the M&L program in Brazil ended. M&L does not have TB core funds to follow-up the impact of the project so that TB indicators could not be collected. |
| Brazil VCT | Decentralize quality VCT services to a micro-region in the state of Ceará and thereby increase access to testing, especially for vulnerable populations | 7 out of 8 planned VCT centers opened and 860 clients were tested as of October 2003 when the program ended with 38% coming from vulnerable groups. Regional lab successfully implemented a system for quality assurance. The program could not be followed beyond the first three months of operation due to the closing of the M&L Program in Brazil. No more funding from the Mission. |
| Egypt MOH | Improve quality of and access to health services in 3 districts and 7 health facilities clinics in the Aswan Governorate | 70% achieved 95% or more of their performance objectives; 10% achieved 33% or objectives; 20% did not demonstrate any progress in achieving objectives.<br>All work groups showed substantial improvement in workgroup climate as of April 2003.<br>Lack of support for the program at the governorate and national level of the Ministry of Health, difficult relations with the CA which has the "bilateral" for USAID population programs, and lack of field support funds led to discontinuation. However, the program is continuing on its own without funding and has been successfully replicated with 15 new teams. |
| Guinea MOH | Improve central and regional level team management and implementation of decentralization | Sustained changes at personal level including better conflict management and listening skills, more generating and seeking feedback, more peer support and networking, better communication between central and regional levels. Leadership Development Program integrated into PRISM[5]. The number of Guinean facilitators was expanded. |

[5] PRISM (Pour le Renforcement des Interventions en IST/SIDA) is an MSH bilateral project in Guinea that began in 1997 and will end in September 2005.

| NAME OF PROGRAM | CHALLENGE | RESULTS |
|---|---|---|
| Indonesia MOH | Assist districts with health planning and financing, improve availability of drugs and contraceptives, and improve community-based surveillance of infectious disease outbreaks | Statutory guidance regarding Essential Public Health Services/Functions issued by the Ministry of Health.<br>Fifteen focus districts/cities are using an effective health planning and budgeting process to strengthen the performance of EPHS/F (target was 2 focus districts).<br>Average availability of 22 drugs from the tracer drug list per survey in 2003 was 70% (target was 55%).<br>Technical assistance has begun to integrate systems for surveillance and outbreak control in focus districts and provinces. |
| Nicaragua MOH | Prepare managers and health workers at the municipal level to assume greater responsibilities and new roles within the context of health sector reform and decentralization. The primary challenge identified within this context was low motivation among health workers. | Organizational climate improved at the municipal and SILAIS levels with greater effect in second and third phases of the Leadership Development program.<br>Very broad participation with nearly 2,000 managers and staff participating over a 3 year period. |
| Nigeria NPHCDA | Complete the construction of 200 health centers while still attending to its basic services of community development and technical training<br>Put in place management systems that can actively and successfully support the organization. | A well-aligned strategic plan and annual operational plan are in place.<br>The basic accounting system is running on new financial software. (A procedures manual will be written and training will be conducted in the coming months.)<br>The 3-month Service Statistics Pilot Program at 12 selected health centers launched in October 2003 was not successful due to the lack of central office travel funds, the non-functioning of the PHCMIS software being developed locally, and lack of the community health care component. |
| Tanzania TACAIDS | Improve Tanzania's ability to coordinate multi-sectoral partnerships and manage the rapid scale-up of the national response to the HIV/AIDS epidemic by strengthening the institutional capacity of the National HIV/AIDS | The District Capacity Assessment was completed, approved, disseminated and used by TACAIDS to define the district and community response.<br>World Bank and Government of Tanzania (GOT) signed the Tanzania Multi-Sectoral AIDS Program agreement.<br>Eight bi-lateral donors signed Memoranda of Understanding (MOUs) with TACAIDS to create the Rapid Funding Envelope (RFE) for HIV/AIDS. |

| NAME OF PROGRAM | CHALLENGE | RESULTS |
|---|---|---|
| | Commission (TACAIDS) | The RFE has completed 3 rounds of grant-making and approved $3.5 million to 23 civil society institutions and partnerships (98% of available funds).<br>The district response strategy was formalized in the National Multi-Sectoral Strategic Framework, approved by TACAIDS in March 2003.<br>Official guidelines published by the GOT in June 2003 created the Council Multi-Sectoral AIDS Committees or CMACs. All 121 districts in the country have named a CMAC.<br>*See the Capture form for Tanzania TACAIDS in Appendix I for additional results achieved that were not in the original M&E plan.* |
| Tanzania PPP | Enlarge the group of health service providers who will implement the essential health package, and create a favorable environment for the formation of partnerships between public and private sector institutions and groups at the district, regional, and central levels. | Not implemented. Due to changing priorities within USAID and the Government of Tanzania, this work plan was suspended |

Among the public sector programs, only Tanzania PPP was unable to show results. Changes in priorities on the part of the Government of Tanzania and the USAID Mission led to the suspension of the program. It continues in PY4 in much reduced form as an activity in one hospital.

The three largest programs, Indonesia MOH, Nicaragua MOH, and Tanzania TACAIDS all achieved or surpassed their performance objectives. These programs have made significant contributions to strengthening leadership and management across entire ministries of health. Indonesia MOH has successfully achieved policy changes to define essential public health functions and minimum service standards that local governments will be obligated to perform. At the same time it has assisted 15 districts to use effective health planning and budgeting processes in order to strengthen the performance of essential functions and services.

Tanzania TACAIDS has pioneered a number of processes that will greatly increase the capacity of the Tanzanian Government to respond to the HIV/AIDS epidemic. The most notable of these is the implementation of the Rapid Funding Envelope for HIV/AIDS, a mechanism whereby funds can be rapidly disbursed to civil society programs. In its first 8 months of existence, the RFE has acquired $3.6 million from 8 bi-lateral donors and awarded $3.5 million to 23 programs implemented by civil society organizations and partnerships.

Nicaragua MOH succeeded in improving work group climate for 1,978 managers at all levels of the Nicaraguan Ministry of Health. By integrating leadership development into routine in-service training, it succeeded in rapidly scaling up the leadership development process. A recent in-depth evaluation highlighted Nicaragua's success in improving work group climate. However, it also raised another issue that all of the large public sector programs face which is the relationship between improvements in leadership and management capacity and improved service delivery.

Although baseline data were available in Nicaragua on service delivery variables such as access to care, the leadership development program was not able to show a correlation between increased climate scores and access at this point in time. The Nicaraguan Ministry of Health identified poor work climate as the cause of low motivation among its staff. They felt that new initiatives to improve management systems and service delivery would founder without improving climate at all levels of the system. The Leadership Development Program in Nicaragua targeted improving climate as its objective and succeeded. However, although improved climate in management teams may be a necessary variable in improving services, it is not sufficient. Other factors such as distance from clinics, hours of operation, and availability of providers all affect access, and none of these were targeted through the program.

One program that addressed the question of linking leadership development with service delivery improvements is Egypt MOH. By targeting clinics and weaving together service delivery improvement plans with leadership development, the program was able to show results in increasing the percentage of family planning users and increasing the average number of antenatal and postpartum visits per client. Seventy percent of teams achieved 95% or more of their performance objectives. Despite the fact that no funding was available to continue the program, participants were so enthusiastic about the leadership development program and their achievements that they decided to continue on their own and enrolled 15 new teams.

Other factors outside of the control of the program can affect achievement of performance objectives. Bolivia CORE/CHEMONICS successfully adapted the CORE tool to help municipalities to track data on service volume, amount of reimbursement from the government's insurance program, operating costs and pharmaceutical information. Unfortunately, although the pilot was successful, the government changed its insurance program and therefore some of the municipalities could not implement the second revision of the tool before M&L assistance (supported with core funds) ended. One of the purposes of the pilot had been to partner with Chemonics. It may be that when there are other underlying reasons for which M&L undertakes particular programs, such as to form a partnership with another CA in response to a mission request, the ability to achieve objectives can be compromised.

The unforeseen closing of the MSH Brazilian office and M&L program significantly impacted the ability of programs in Brazil to demonstrate long term results, despite the fact that the programs succeeded in achieving most of their desired objectives. Both Brazil VCT and TB DOTS demonstrated that vertical programs can be integrated into family health teams working in municipal clinics. Seven out of eight clinics in the region of Juazeiro do Norte, Ceará set up VCT centers where 860 tests were carried out between August and October 2003. A system for guaranteeing the quality of the laboratory analysis was set up as well as an information system to track testing and results. In the TB DOTS program, a quality improvement approach was used to define standards for TB detection and treatment in partnership with family health teams. Directly observed therapy short course is the cornerstone of effective TB treatment. The two clinics that participated in the program successfully referred all persons who were symptomatic for testing and began treatment of those who were positive for TB in their communities. Because USAID did not financially support the M&L Program in Brazil after November 2003, both programs were only able to provide services for three months, and their sustainability is unknown.

The last client in this cohort, Nigeria NPHCDA, is not strictly public sector but parastatal. It is early in program implementation, but the program has succeeded in achieving most of its objectives. A well-aligned strategic plan and an annual operational plan are in place. The basic accounting system is running on the new financial software, a procedures manual will be written, and training will be conducted in the coming months. This program will also eventually face the issue of defining what will result from these management improvements.

### 4.11 To what degree did clients in NGO programs achieve their performance objectives?

Table 8 below compares the challenges and results for the eight NGO programs.

**Table 8. Results for Eight NGO Programs**

| NAME OF PROGRAM | CHALLENGE | RESULTS |
|---|---|---|
| Bolivia COMBASE | To improve performance in the hospital and clinics (5) in their Christian evangelical network in order to become more financially sustainable | Although a court case with the previous director of the board delayed activities for 2 years, there are beginning signs of results.<br>Organizational planning units are beginning to use MIS data.<br>Four out of five clinics have become self-sufficient in terms of covering costs. |
| Bolivia PROCOSI Business Planning (BPP) | To enable 8 members of PROCOSI's NGO network to access alternative sources of funding so that they can become financially sustainable in light of reduced USAID funding and legal requirement to offer care to the poor at no cost. | Six (6) of eight participating organizations completed the program.<br>Total revenue received as of May 2004 by participant organizations was $350,000.<br>The program was transferred to PROCOSI which delivered it to NGOs in Nicaragua beginning in March 2004.<br>Domestic delivery of the program in Bolivia was postponed due to delivery in Nicaragua. |
| Bolivia PROSALUD | To re-engineer management systems and processes in order to strengthen overall financial sustainability after the end of USAID support | Processes and procedures for management systems have been modernized.<br>Roles, responsibilities and functions for each level have been described.<br>Manuals for systems have been completed.<br>Job descriptions, have been revamped.<br>However, the overall model has not yet been implemented. PROSALUD has lacked a champion to transmit urgency to others, including the Financial Director, who is reluctant to implement. The program will continue through PY5. |
| Brazil HIV/AIDS NGOs | Improve financial sustainability and strengthen overall management of 4 HIV/AIDS NGOs in the poor Northern region of Brazil | On a scale of 1- 4 the mean management performance of the four NGOs with regard to their mission increased from 2.5 to 3.6; mean strategic planning scores increased from 2.5 to 2.9; and mean management systems scores increased from 1.4 to 1.8.<br>Results for human resource management were mixed. Two NGOs met or exceeded their target score and two remained at their original level of 1.<br>The NGOs are in the early development phase and did not collect financial data to allow us to know if financial sustainability improved. |

| NAME OF PROGRAM | CHALLENGE | RESULTS |
|---|---|---|
| Guatemala<br>APROFAM | To prepare APROFAM for significantly reduced international donor support by generating alternative sources of revenue through the conversion of the Rural Development Program (RDP) into a social marketing program | The percentage of self-financing increased from 52% in 2002 to 58% in 2003. In the 4 departments where the RDP had been implemented the increase was to 70%.<br>Other indicators cover the whole organization and not just the RDP:<br>• Total Couple Years of Protection (CYP) increased from 109,951 in 2002 to 131,020 in 2003.<br>• Total services delivered increased from 93,298 in 2002 to 103,758 in 2003.<br>• Composite quality index decreased from 82% in 2002 to 78% in 2003 due to increased demand for services in certain clinics which led to lower client satisfaction scores |
| Honduras<br>ASHONPLAFA | To increase financial sustainability from 30% to 70% in 2007 | The strategic plan is 75% complete - all components of the strategic plan are complete, but not yet fully integrated into one document and therefore not yet disseminated to regional teams.<br>The administrative manual for institutional marketing unit has been completed.<br>Indicators have been defined for monitoring the market, competition, and sales.<br>Baseline financial sustainability in 2002 was 62%. Post intervention values are not known. |
| Nicaragua<br>PROFAMILIA | To strengthen organizational and financial sustainability and leadership at all levels in the context of loss of USAID funding | Financial sustainability was increased.<br>*Indicator:* % of annual operating budget covered by income generated through service delivery<br>Cuts in personnel and increases in sales improved this indicator which went from 44% in 2001 to 46% in 2002, 55% in 2003, and 99% in the first three months of 2004.<br>By June 2003, a new management information system will be piloted.<br>*Indicator:* Copy of MIS consultant's final report or trip report<br>MSH addressed leadership needs during PY3 at the request of PROFAMILIA, and financial and management systems strengthening was delayed until PY4. At the time of this review in May 2004 the MIS system has been piloted. |

| NAME OF PROGRAM | CHALLENGE | RESULTS |
|---|---|---|
| Peru Manuela Ramos | To ensure organizational efficiency, and medium term sustainability by identifying and promoting new leaders, introducing a processes for reflection and analysis, establishing a modern governance structure that preserves organizational values, and programming an image that is consistent with those values | A limited budget of $50,000 narrowed the scope of the program to only the initial phase of the Performance Improvement process of identifying challenges, gaps and performance objectives. The USAID mission allocated all available funds to Catalyst so that even though Manuela Ramos requested more TA from MSH, this was not possible.<br>The PI process was successfully used to identify a process for promoting new leaders and suggesting changes in governance structure. The planning unit was strengthened with additional resources to generate new proposals and undertake M&E activities. The governance structure was improved to support a decision-making process. Institutional values were identified. |

Institutional and financial sustainability are the themes that run across the eight NGO programs. M&L applied varying approaches and the NGOs achieved varying results, some highly successful and some less so. One of the greatest difficulties M&L faced in its assistance is that of helping the NGOs implement the changes that have been designed to increase sustainability. Bolivia PROSALUD faces a finance director who is reluctant to change, and without strong leadership from the top there is not enough pressure to ensure implementation. In the case of Bolivia COMBASE, a court case with the previous director of the board was a stumbling block to implementing changes, although there are encouraging signs that creative marketing and committed physicians have enabled four out of the five clinics in their network to become self-sufficient.

M&L worked with four fledgling HIV/AIDS NGOs in the poor Northern region of Brazil and succeeded in improving their mission, strategic planning and management systems as measured by APOGEE (MOST) scores. The closing of the M&L program had less of an effect on this program which was well underway before December 2003. Although the NGOs had no systems for collecting financial data, anecdotal evidence from the Brazilian National AIDS Control Program shows that these four NGOs are perceived as leaders in their region and have begun to encourage other NGOs to address their management challenges.

Honduras ASHONPLAFA succeeded in achieving the majority of its performance objectives. As of the program's close in June 2003 when USAID funding ended, the strategic plan is 75% complete, although not yet disseminated; the administrative manual for institutional marketing unit has been completed; and indicators have been defined for monitoring competition and sales. As in the case of Brazil HIV/AIDS NGOs, the program has ended and we do not have access to financial data that could demonstrate if the challenge of improving sustainability has been met.

Nicaragua Profamilia's performance objective was to increase financial sustainability, but the program was only able to work on the leadership component of the intervention during PY3. Only now in PY4 has work on the management information system been completed. Nonetheless, by cost cutting and increasing sales, PROFAMILIA has been able to increase the percentage of annual operating budget covered by income generated through service delivery from 44% in 2001 to 46% in 2002, 55% in 2003, and 99% in the first three months of 2004.

Peru MANUELA RAMOS was successful as a pilot to assess if the Performance Improvement approach could be applied to help them face the underlying factors that will determine their sustainability. For reasons that have to do with the USAID mission's unwillingness at the time to continue funding M&L's involvement, this program could not go the next step of implementation of the proposed changes.

Two of the most innovative programs, Bolivia PROCOSI BPP and Guatemala APROFAM, were both successful in helping clients reach their performance objectives. Six out of the 8 NGOs completed the BPP and produced acceptable business plans. The emphasis of the program on helping the NGOs go through each step to actually produce the business plan resulted in total revenues of $350,000 for the participating NGOs as of May 2004. PROCOSI successfully facilitated the next roll-out of the program in Nicaragua. Because the impact of the project is measured by the participant NGOs actually receiving funding, there is a need for monitoring the NGO's progress beyond the period of program implementation.

Guatemala APROFAM succeeded in increasing couple years of protection from 109,951 in 2002 to 141,020 in 2003 and increased total services delivered from 93,298 to 103,758 in the same period. The Rural Development Program (RDP) was the most successful aspect of the intervention under M&L. There is evidence that the percentage of self-financing increased from 52% in 2002 to 58% in 2003 and to 70% in the 4 departments where the RDP had been implemented. There is another lesson from this project, however, that demonstrates one of the risks of helping an organization to achieve self-financing: APROFAM is at risk of losing its strongest argument for donor support - serving largely the very poor who do not have access to other alternatives. Income-generating services for fee-paying clientele are by definition not focused on those most in need. By maximizing efficiency and the self-financing potential of its programs, APROFAM's social responsibility towards those who cannot pay is less emphasized. The organization's leadership continues to pursue donor support for more income generating services and programs, rather than using its hard won flexibility to address areas of critical need in the country.

Overall, the results for NGOs show that institutional and financial sustainability can be greatly improved, but that implementation of the required changes is sometimes difficult and slow in coming. The kinds of changes that are necessary in leadership at the top of these organizations to make this happen does not seem to be addressed as often in M&L's NGO programs as in their public sector programs.

## 5. CONCLUSIONS

The objectives of the Cross Program Review were to:

1. Provide an overall representation or macro-level view of M&L's work in improving leadership, management, and sustainability of organizations and programs
2. Offer evidence of M&L's success or failure in helping field programs achieve their performance objectives
3. Provide information to guide future M&L technical assistance

Analysis done in order to achieve the latter two objectives resulted in several important lessons for M&L:

### 5.1. Evidence of Success or Failure

**Progress has been made on a number of fronts in helping clients to achieve their performance objectives**

Out of the eighteen projects reviewed, only Tanzania PPP was unable to achieve its performance objectives, and the reasons for this lie more in shifting donor priorities than in any inherent problem with how the program was designed. All of the other projects were able to help clients make significant progress towards their goals. Programs can help clients achieve their performance objectives to a greater degree when there is a minimum of two years of funding so that programs have a chance to get stakeholder buy-in, develop well designed interventions, implement changes in a sustainable way, and document medium-term results. In the case of the public sector, larger programs that can intervene at all levels of a health care system over a longer period of time have a greater chance of achieving their client's performance objectives. In

the case of NGOs, institutional and financial sustainability can be improved, but it can take longer than expected for interventions to be taken up by NGO staff and become permanent.

**Programs vary in how well they are able to demonstrate the impact of management and leadership strengthening on health services.**

The demonstration of impact at this level is a function of whether interventions are focused on the district level and below (as opposed to the regional or provincial level and above) and the length of time for which M&L has funding (core or field support) to work with the client organization.

In the early years of the M&L program there was a greater emphasis on documenting internally focused results such as implementing a new financial reporting system, helping a client to develop a well aligned strategic and operational plan, or strengthening the leadership of managers in the organization. Most of the programs reviewed here began in 2002 before M&E liaisons were assigned to work with program managers to refine desired outcomes to reflect the impact on services. It was difficult for most of the programs reviewed for this report to show impact on services for a number of reasons:

- Gathering baseline data is time consuming and expensive, especially for small NGOs. Some clients did not have the systems in place for routine data collection.
- The intervention may be addressing a level, such as the central level of a ministry of health, that is too far removed from services to be able to make the link
- It is not always clear which aspect of service delivery would be more likely to show change unless it is specifically targeted in the intervention

Most of these programs were not designed from the outset to demonstrate correlations with improved services, therefore either baseline data were not collected, or the intervention did not target service delivery as an explicit component of the program. Knowing which service delivery component will be most affected by M&L's interventions has not been sufficiently researched so that program managers can plan for data collection at the beginning of the program. For example, the recent Nicaragua MOH in-depth study looked at service delivery data such as access before and after the program was delivered. However, access may not be where the intervention had its greatest effect, and monitoring quality of services may be more appropriate. Measuring quality pre- and post-intervention can be extremely time-consuming and expensive if these data are not routinely collected. Each program needs to analyze what the pathways to change are and trace the program logic to assure that the program can be expected to impact those pathways. Programs can also benefit from technical input concerning service delivery improvement. This input can be provided by a bilateral project, as in the case of the PRISM Project in Guinea, or by an M&L program focused on service delivery as in the case of Nicaragua "Bridge Project."

**M&L's ability to show results, especially in terms of services, depends on the clients' own M&E systems, specifically their ability to provide accurate baseline data and end-of-project data.**

Another challenge is that of M&L's responsibility to improve an organization's system for data collection if that is not an explicit aspect of the intervention. Brazilian NGOs in the northern region are only in the early phase of operation and do not have the resources to do routine client surveys. M&L was able to improve management systems in the one-year implementation of the

program, but did not see provision of technical assistance to the NGOs in setting up their own systems for monitoring and evaluation as its mandate. In the Egypt MOH program, indicators used by the district and clinic teams needed to conform to those routinely used by the MOPH. However, these were not necessarily the indicators that were most appropriate for the project. The 2003 in-depth evaluation of the Egypt program showed that the clinics are greatly in need of assistance in developing the correct indicators and data collection methods for monitoring their action plans. If our measures of success are linked to our clients' ability to demonstrate impact on services, M&L will need to extend its technical assistance to strengthening our clients' M&E systems as these have an impact on our own M&E capability.

### 5.2. Key Findings to Guide Future M&L Technical Assistance

**The financial sustainability of NGOs can be improved, but care needs to be taken to ensure that services for populations in need are not compromised in the process**

Bolivia PROCOSI BPP, APROFAM Guatemala, Bolivia COMBASE and Nicaragua PROFAMILIA demonstrated that NGO financial sustainability can be improved. Creative solutions developed in the business planning program and in APROFAM's RDP resulted in expanded donor funding for the former and increased self-financing for the latter. However, helping NGOs to continue to subsidize programs for populations that cannot pay is a challenge. Bolivia COMBASE relies on a dedicated team of Christian evangelical providers who are willing to take lower salaries, while Nicaragua PROFAMILIA cut costs and trimmed staff. APROFAM has not yet completed the transition from reliance on external donor funding to self-financing, and the leadership has not quite yet determined how fee-paying services can subsidize programs for populations that cannot afford to pay. These issues are likely to take on even greater importance for NGOs in countries where the public sector is unable to shoulder this responsibility.

**Technical assistance in management development should be accompanied by parallel assistance in leadership development, or at least change management, as a means to assure that system changes are fully integrated and institutionalized into an organization's standard operations at all levels of the organization (i.e., headquarters, regions or branches, and clinics).**

Evidence noted above concerning the delay in progress of the re-engineering process in Bolivia PROSALUD, the absence of a champion, and resistance by the Finance Director to change, is one example of the risk of undertaking large-scale and complex management improvement projects without the active support of senior leadership. In such instances, an active champion is needed. The risk of less than desired outcomes is greater when M&L does not have a field presence to serve as the champion or driving force of progress, as in the case of Bolivia CHEMONICS.

**Similarly, technical assistance in leadership development should be accompanied by parallel assistance in key management areas, especially information and logistics management and quality assurance.**

The Leadership Development Programs in Nicaragua and Guinea have benefited from the presence of MSH bilateral programs that both facilitated the introduction of M&L into the countries and served as champions of the interventions between short-term TDYs by M&L staff.

In the case of Nicaragua, as the Leadership Development Program began to expand, M&L facilitators handed off to staff in the former bilateral program. Both bilaterals have focused a great deal of their technical assistance on strengthening key management systems of the respective MOHs. When M&L is working at the district level and below and the desired outcomes of leadership development are defined as changes in service delivery performance, positive outcomes are more likely, and the risk of frustration on the part of participants to less than desired outcomes are minimized, if key management systems related to effective service delivery are functioning well, and if not, there is at least an ongoing effort to improve their performance.

While M&L will not always find opportunities to address the strengthening of leadership capacity and effective functioning of management systems in parallel, and the absorptive capacity of the client (especially small NGOs) and the public sector to effectively receive such simultaneous attention should be borne in mind, M&L must be alert to the risks of "single focus" interventions (leadership development or management systems development) falling short of expectations.

**Sustainability of programs in the public sector may require intervening at more than one level**

The three public sector leadership development programs reviewed here — Egypt MOH, Nicaragua MOH, and Guinea MOH — used different approaches that may influence sustainability in the long run. While we have not yet followed these programs for a sufficient length of time, it is still worthwhile to consider which strategy proved most effective. Is it more sustainable to affect climate broadly among nearly 2,000 workers in a health system, as was done in Nicaragua, and concurrently focus on management improvements that will lead to better services? Or is the approach used in Guinea of first changing hearts and minds at the highest level of the ministry more likely to be successful over the long term as the MSH bilateral program continues provides TA to strengthen key management systems that could lead to improved services in health units at lower levels?

In Egypt, despite the lack of support at the central level, the program was able to work at the service delivery level in three districts and seven health facilities in the Aswan Governorate. By focusing on the service delivery level, the program was able to inspire nurses and doctors to face their challenges and achieve results. Lack of support at higher levels, however, has left the clinics with very little in terms of material resources. It is questionable as to what degree they can further continue. The 2003 evaluation showed that clinics were focusing only on those outcomes they could affect with existing resources available to them. These may not be the critical areas that need to change, and without financial support from the central and Governorate levels, the clinics may not be able to sustain their performance leading to possible frustration and failure.

**M&L's ability to track organizational performance over the long-term following the completion of a project is limited if Mission funding or core funds from USAID/W are not available. This is especially the case in instances where USAID has withdrawn population funding.**

Brazil VCT and Brazil TB DOTS demonstrated in a short period of time that access to voluntary counseling and testing for HIV/AIDS, and access to diagnosis and treatment for TB could be improved. It also demonstrated that systems for guaranteeing quality could be implemented with decentralization to family health teams operating at the municipal level. However, Population funding was not available for follow-up. Systems improvements could not be followed over a long enough period of time to demonstrate sustainability, in the case of the VCT program, or to show improvements in detection rates and treatment outcomes, as in the case of TB DOTS. The ability to document these outcomes is especially critical as VCT and DOTS programs are being scaled up to address the epidemics of HIV/AIDS and TB.

**M&L should align its collaboration with other Cooperating Agencies (CAs) in the field to complement CA assistance in service delivery**

During M&L's collaboration with Chemonics in Bolivia, M&L responded rapidly to the Mission's request to collaborate with Chemonics, and used core funds since field support funding was not made available. However, Chemonics finished activities before M&L's program ended and there was therefore no longer an on-site presence to support the municipal health managers. It could not be anticipated that the government would change its policy, necessitating a second adaptation of CORE. However, the intervention was nonetheless quite complex and because of this, more time to implement the program should have been foreseen. This time was needed to assure that the municipal managers could successfully integrate the use of the adapted CORE tool in their routine operations. M&L programs should assure that adequate funding is available to complete all proposed work, and that the collaborating CA will be working with the client throughout the entire period of proposed assistance.

M&L is now actively conversing with several service delivery CAs to identify possible areas for collaboration and complementarity in the future. The lesson of the Chemonics experience should be borne in mind.

**M&L has experience with both the public sector and NGOs that can be leveraged in the future to build capacity for scaling up services.**

This cross-program review looked across a broad range of M&L interventions at a particular point in time. The twin themes of decentralization for public sector programs and sustainability for NGOs are extremely timely and will be especially useful as M&L continues to strengthen the management and leadership of HIV/AIDS, family planning/reproductive health, and maternal/child health programs in Africa and other regions where the need is great to rapidly scale up services. M&L can also use the results of this review to strengthen its M&E system. In the future this may require expanding the M&E Unit's role to allow it to provide direct technical assistance to client organizations in M&E. It may also require securing funding to be able to document clients' progress over a longer period of time. This review provides evidence of the breadth of M&L's success in very different contexts and adds to the body of in-depth evaluations and studies that enable the M&L Program to continuously learn and grow.

## Appendix I: Individual Country Program Capture Forms

**Bolivia COMBASE**

| Data Field & Source | |
|---|---|
| Project Manager | Elena Decima |
| Organization Type (NGO, government, private, etc) | NGO |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Clinic<br>Hospital (one small general hospital and 5 health clinics |
| Organization's Geo. Coverage (national/provincial/district) | Municipal |
| Types of challenge or problems identified by the organization | This Christian evangelical NGO provides health services to a low income population, especially women and children. They recognized the need for performance improvement to become more financially sustainable. They identified a number of root causes for performance problems including:<br>• poor management and leadership<br>• non-existent work processes (information, planning, etc.)<br>• lack of resources<br>• lack of knowledge of management<br>• insufficient prioritizing of financial sustainability and diversification of funding sources, etc |
| Type of Performance Objectives | 1. By June 2003, COMBASE managers will be administering their hospitals and clinics according to the 2003 Annual Operational Plan.<br>2. By June 2003, COMBASE management information system software is adapted and developed<br>3. By June 2003, COMBASE will have reduced costs and increased revenues |
| Type of M&L Intervention | 1. Developing and monitoring 2003 annual work planning process<br>2. Development of new Management Information System.<br>3. Evaluation of administrative, financial &HRM processes.<br>4. Initial capacity building of Board of Directors and Exec. Director<br>5. Ongoing TA in financial sustainability |
| Type of System that was addressed | Annual operational planning<br>Information System<br>Human Resource Management<br>Financial Management<br>Administrative<br>Board of Directors and Executive Director<br>Financial Sustainability/business planning |
| Received TA from MSH in past | In PY2 Application of MOST, application of CORE in hospital and health clinics, operational planning, financial management |
| Tools or approaches used in | Discussions/meetings with stakeholders |

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| developing PPI | Management and Organizational Sustainability Tool (MOST)<br>Cost Revenue (CORE) Analysis Tool |
| Duration of intervention | July 2001 through PY5 |
| Cost of Intervention | $164,656 |
| Indicators Used | 1. Organizational planning units use MIS data<br>2. The annual operational plan is used to monitor activities and outputs<br>3. The financial management system produces accurate, timely information on expenditures<br>4. The annual operating budget is partly covered by income generated through service delivery |
| What were the results | Met with Elena Decima to get results. Most of these activities have taken a lot longer to implement and are in progress as of this writing.<br>1. Not yet implemented - in progress<br>2. Beginning based on AOP for Jan-Dec 2004<br>3. First report produced in 4/04<br>4. Four out of five clinics and the hospital have become self-sufficient in terms of covering costs |
| Other factors | Problems with former head of board of directors resulted in a court case that has tied up the organization for 2 years. Case was resolved in favor of COMBASE but everything was delayed. According to ED their mentality has changed to realizing that they are in charge of their own future. Several of the clinics have held health fairs to get new business for example. They have hired young evangelical health care providers who will work for less pay and are very motivated. A few years ago COMBASE was written off but now it may be that they are able to show some surprising results. |

**Bolivia CORE/CHEMONICS**

| Data Field & Source | |
|---|---|
| Project Manager | Elena Decima |
| Organization Type (NGO, government, private, etc) | Government |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Clinics<br>Municipal health departments |
| Organization's Geo. Coverage (national/provincial/district) | Municipal |
| Types of challenge or problems identified by the organization | Since 1994 Bolivia has embarked on a decentralized process at the municipality level. While decentralization efforts have brought financial assistance to the municipalities and increased their responsibilities, there has not been a parallel effort of management support to assist municipalities in carrying out their new roles and responsibilities. Need for a tool that allows users to prepare and access information on service volume, amount of income (reimbursement from government's SUMI (Universal maternal and child health insurance) program and income from other services, operating costs, estimated pharmaceutical usage (based on service volume and specified quantities in treatment protocols) and financial control for the Municipal Institutional Pharmacy |
| Type of Performance Objectives | Develop and strengthen the financial management capacity of selected municipalities through the use of an adapted-for -Bolivia CORE tool (SCES or CORE Plus) |
| Type of M&L Intervention | M&L's technical assistance focused on completing the collaboration started with Chemonics (through their Democratic Development and Citizen Participation (DDPC) program) in FY03. Together with DDPC, MSH first adapted the CORE tool to the SUS (Universal Health Insurance), and later readjusted this first CORE Plus to the new SUMI to better manage SUMI and the health centers under their financial supervision. |
| Type of System that was addressed | Financial Management |
| Received TA from MSH in past | No |
| Tools or approaches used in developing PPI | CORE |
| Duration of intervention | July 2001 – June 2004 |
| Cost of Intervention | $89,659 |
| Indicators Used | 1.1 Manual for SCES tool is finalized.<br>1.2 SCES final version is designed and validated in two municipalities of Pando.<br>1.3 SCES is evaluated in Pando. |
| What were the results | 1.1 Completed: MSH's section of the manual have been completed; publication of the manual has been delayed pending the publication, by the government, of the official essential drugs list (or SALMI) portion. This list of medicines has not been incorporated<br>1.2 Completed: The final version of the SCES/Core Plus tool was completed in June 2003; during the period July-November the tool was disseminated and personnel were trained.<br>1.3. Completed: Evaluation conducted in Nov. 2003. Report in draft form on "I" drive |
| Other factors | The application and dissemination of SCES has suffered with the recent political |

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| | upheavals of the country. Nevertheless, the information so far collected from the municipalities who are using or have used the last 2 version of SCES is that the tool permits a fairly quick revision of the volume of services and reimbursement amount, easy identification of errors and a quick processing of the payments. Both the Municipalities Association of Pando and the Pando office of PROSIN have expressed their enthusiasm for the use of the tool but all recognized that more dissemination and training are needed.<br>The short term outputs were achieved but the longer term outcomes of actual implementation of the tool in the municipalities was not achieved for several reasons: 1) The government changed its insurance program and 2) MSH had no value added to offer in terms of funding for continued training. Part of the underlying rationale for the project was to partner with Chemonics which ended its program in 9/03<br>As a pilot of the tool the intervention was successful, but it was not able to have lasting effects |

**Bolivia BPP PROCOSI**

| Data Field & Source | |
|---|---|
| Project Manager | Judy Seltzer |
| Organization Type (NGO, government, private, etc) | NGO Network of 24 other NGOs |
| Type of sector where the client operates (health, agriculture, etc.) | Health<br>Microenterprise<br>Agriculture<br>Education |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Community |
| Organization's Geo. Coverage (national/provincial/district) | National |
| Types of challenge or problems identified by the organization | Achieving sustainability is a long-term goal for the PROCOSI network. PROCOSI and its member organizations have received funding primarily from the United States Agency for International Development (USAID) and the European Union (EU). While charging fees for services and certain products (e.g. vaccines, contraceptives) was once a strategy to recover costs, Bolivian law now requires NGOs to offer a basic health care package to the poor at no charge. NGOs receive insufficient reimbursement from the government for such services.<br>The member organizations want to diversify and expand their funding streams by seeking investment from nontraditional sources such as individual philanthropists, foundations, and private corporations. |
| Type of Performance Objectives | Strategic Objective: PROCOSI Member NGOs expand and diversify their funding base<br>Outcome #1:<br>NGO Business Plans receive funding<br>Breakthrough product or service developed as proposed in the Business Plans<br><br>Outcome #2:<br>PROCOSI replicates Business Planning course for other NGO members |
| Type of M&L Intervention | Eight member organizations and the PROCOSI Secretariat participated in the pilot program. *The Art of Crafting a Business Plan for Social Return on Investment* uses both face-to-face and electronic methodologies to guide participating organizations through six modules to develop a business plan. Participating organizations work in teams of two to five individuals. Throughout the business planning process, participants gain skills and expertise in such areas as: articulating and packaging breakthrough ideas, identifying a product design team, scheduling product development and roll-out, conducting market research, estimating financial and other resource needs, and projecting social returns on investment. Each of the six modules corresponds to a section of the business plan. Teams complete each module and then send their work to an assigned reviewer/program facilitator for feedback. Upon completion of the six modules, the components are integrated into a complete business plan. |
| Type of System that was addressed | NA |
| Received TA from MSH in past | Since before 1998 Under FPMD II |

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| Tools or approaches used in developing PPI | Blended Learning modules |
| Duration of intervention | July 2002-July 2004. The program was delivered from July to December, 2002 in Bolivia but will continue to work with PROCOSI to deliver the program in Nicaragua through June 2004 |
| Cost of Intervention | $119,190 |
| Indicators Used | OUTCOME #1<br>% of Business Plans that are funded within 6 months of course completion<br>% of new products or services launched as outlined in the Business Plans within 12 months of course completion<br># of participating NGOs that have produced a Business Plan that meets course criteria for sound business plan<br># of participating NGOs that complete entire 6 module Business Planning course<br>OUTCOME #2<br># of training replications using the Business Planning platform in the 12 month period following completion of first course<br># of NGOs trained by PROCOSI in Business Planning in the 12 month period following completion of first course<br># of PROCOSI staff trained to facilitate and offer Business Planning course to other NGO clients.<br>Business planning course is refined/revised following first course completion based on participant results and feedback<br>Roster of potential funders developed |
| What were the results | Six of the eight participating organizations were trained in the BPP technology, completed the program, and developed business plans that met the facilitators' criteria of a "sound business plan."<br>NGOs continue to look for funding for products and services identified in their plans. Total revenue received as of 5/04 by participant organizations: $350,000.<br>The second primary outcome of this pilot was the transfer of the program to PROCOSI. PROCOSI has assumed ownership for replicating and distributing the program in Latin America. As of 03/04, PROCOSI delivered the BPP for the first time with assistance from MSH to NGOs in Nicaragua. Domestic use of BPP with other clients has been postponed until 06/04 due to high international demand. |
| Other factors | |

**Bolivia PROSALUD**

| Data Field & Source | |
|---|---|
| Project Manager | Elena Decima |
| Organization Type (NGO, government, private, etc) | NGO |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Clinic<br>32 health care facilities |
| Organization's Geo. Coverage (national/provincial/district) | National |
| Types of challenge or problems identified by the organization | USAID Bolivia's support of PROSALUD is scheduled to end within the next few years. Under the current PROSALUD /USAID Bolivia contract, PROSALUD is expected to further improve the organization's financial sustainability. In order to strengthen overall sustainability (organizational, financial and programmatic), PROSALUD and M&L agreed, after careful evaluation, that a thorough re-engineering of all of the management systems and processes was necessary. |
| Type of Performance Objectives | Key elements of PROSALUD new decentralized organizational management model are designed, including: redefinition of roles and responsibilities and functions at different levels; re-engineering of all management systems and their corresponding processes and procedures; new organizational structure and job positions; training and implementation plan to implement new model in PY4. |
| Type of M&L Intervention | The intervention chosen to close the gap is the design of a complete modernization of PROSALUD's management model: organizational processes and procedures of all of the organization's management systems, the organizational structure, job positions, etc.<br>Phase I: Development of the conceptual framework for the development of the process<br>Phase II: Redefinition of roles, functions and competencies for each level in the institution (central level, regional level and local level)<br>Phase III: Documentation and optimization of processes and procedures for the various management systems of the organization<br>Phase IV: Up-dating of job positions and the organizational structure<br>Phase V: Review of existing instruments and tools for different processes and systems and refinements and/or development of these tools and instruments.<br>Phase VI: Design of strategic management control system<br>Phase VII: Development of the implementation and training plans to put the newly designed management model of PROSALUD into effect in PY4 |
| Type of System that was addressed | Supervision System<br>Financial Management<br>Human Resource Management<br>Information System |
| Received TA from MSH in past | MSH provided TA from 1985-89 & 2001: Financial Management, Human Resources Development, Information Systems, Logistics Management, Service Delivery Operations/QA, Strategic Planning, Supervision, Sustainability/Business |

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|---|---|
| | Planning, Leadership Development |
| Tools or approaches used in developing PPI | Discussions/meetings with stakeholders<br>Review of organizational processes, systems and results |
| Duration of intervention | July 2002 through PY5 |
| Cost of Intervention | $248,988 |
| Indicators Used | OUTCOMES<br>• Document describing methodology for entire re-design process<br>• Participant evaluations and other information in trip reports attesting to participatory development of entire model |
| What were the results | Most of the outputs have been accomplished in terms of the models developed but they haven't "landed" and been adapted to PROSALUD's reality.<br>1. All processes and procedures for all management systems in PROSALUD have been modernized and decentralized. Roles, responsibilities and functions for each level have been described. Manuals for systems have been completed. Job descriptions, organizational structure have been revamped. All of this is only in model form but not yet implemented.<br>2. All organizational processes were enhanced, including HRM. Implementation is ongoing<br>3. All systems and processes in PROSALUD have been modernized and decentralized according to discussion and definition of roles and functions of different levels in the organization – In progress<br>4. Administrative manuals have been completed with exception of one system which will be completed in PY4.<br>5. Jobs were re-profiled according to decentralization plans and staff trained in new functions – Only with National managers<br>6. Employee planning and evaluation system complete.- Not accomplished |
| Other factors | Implementation ongoing in PY4. According to Elena Decima, this project has lacked leadership at the top of PROSALUD to push for the necessary changes and transmit urgency to staff lower down in the organization.. Implementation in the face of change has been the difficulty. Behavior change is the main barrier. |

**Brazil HIV/AIDS NGOs**

| Data Field & Source | |
|---|---|
| Project Manager | Xavier Alterescu/Karen Johnson Lassner |
| Organization Type (NGO, government, private, etc) | NGO (4) |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Community |
| Organization's Geo. Coverage (national/provincial/district) | Regional |
| Types of challenge or problems identified by the organization | Sustainability and overall management strengthening -The rapid scaling up of NGOs in Brazil in response to a flowering of civil society organization in general has meant that many of them are weak in management. The Brazilian National AIDS Program, requested that MSH do Brasil focus management strengthening on the North- the poorest region with the weakest NGOs. |
| Type of Performance Objectives | Mission prepared, disseminated and applied<br>Strategies defined and coherent<br>Management systems strengthened |
| Type of M&L Intervention | In September 2002 MSH conducted management assessment workshops with each of the four NGOs, using APROGE (MOST). These assessments resulted in management development action plans, all of which indicate the need for technical assistance in the following areas: re-formulation of by-laws, strategic planning, human resources management, financial management and fundraising. To meet these needs, between December 2002 and October 2003 MSH conducted strategic planning, bylaws revision, human resources management, financial management and fundraising workshops with the staff of each of the four NGOs. In October and November 2003, MSH conducted final management assessment workshops with each of the four NGOs, using APROGE and focus groups, in order to measure the results achieved, both quantitatively and qualitatively. |
| Type of System that was addressed | Financial Management<br>Human Resource Management<br>Planning-Collection and use of information |
| Received TA from MSH in past | No |
| Tools or approaches used in developing PPI | APROGE (MOST)<br>Participatory Strategic Planning (Planejamento Estratégico Participativo) |
| Duration of intervention | September 2002-October 2003 |
| Cost of Intervention | $747,767 (includes expenditures on other activities in HIV/AIDS work plan) |
| Indicators Used | The mission statement is understood and applied<br>A well-aligned Strategic Plan<br>Human resource activities are carried out according to the current human resource plan |
| What were the results | Between 2002 and 2003 on a scale of 1- 4 the management performance of the four NGOs with regard to their mission increased from 2.5 - 3.6, with regard to strategic planning |

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| | scores increased from 2.5 to 2.9, with regard to management systems, scores increased form 1.4 to 1.8.<br>MSH provided technical assistance to improve financial sustainability, but without a baseline and follow-up measure there is no way to know if this improved.<br>Results for human resource management were mixed. Two NGOs met or exceeded their target score and two remained at their original level (1) |
| Other factors | The MSH do Brasil office closed in December of 2003 so collecting additional information on progress has been difficult. At a meeting of the National AIDs Control Program in 4/04, the leader of one of the NGOs(GAPA/PA) attested to the excellent work of MSH in providing management TA. He also said that they (GAPA/PA) are now helping other NGOs in the state with strategic planning, based on their experience with MSH. At the same meeting, a staff person from then National AIDS Control Program also said that following MSH's TA there was a tremendous improvement in capacity in the 4 NGOs in the north and that these NGOs are now "light years ahead of other NGOs in the region.that didn't receive TA (per e-mail from Karen Johnson Lassner) |

**BRAZIL TB DOTS**

| Data Field & Source | |
|---|---|
| Project Manager | Roberto Brant/Lia Kropsch |
| Organization Type (NGO, government, private, etc) | Government |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Municipal TB Control Program<br>Health Center |
| Organization's Geo. Coverage (national/provincial/district) | Municipal (similar to district) |
| Types of challenge or problems identified by the organization | DOTS coverage currently reaches only a small proportion of the population, there is increasing awareness among Brazilian health officials that DOTS coverage should be expanded. Evidence of this increased awareness and commitment includes the recently developed MOH TB control strategic plan for 2001-2005, designation of the Family Health Program (PSF) as implementers of DOTS at the municipal level, prioritization of 329 municipalities (representing 80% of all TB cases in Brazil) RJ SES PCT selected Duque de Caxias to be the first priority municipality to receive direct support for implementation of DOTS. Of the 11 priority municipalities in Rio de Janeiro State, Duque de Caxias municipality had the second largest TB incidence (140 cases per 100,000 population) in 2000 and the second largest number of cases (1,088) compared to other municipalities in the state. |
| Type of Performance Objectives | 1. Strategies are employed to promote treatment seeking with the goal of increasing the case detection rate to 90%<br>2. Systems are implemented for treatment of smear positive cases using directly observed therapy<br>3. Increased adherence to treatment leading to improved cure rate of 85%<br>4. Information systems are in place to assist in the effective management of the DOTS program<br>5. The Municipal Government of Duque de Caxias is committed to the implementation and sustainability of a TB control program using DOTS strategy |
| Type of M&L Intervention | Guidelines/norms Development in TB DOTS<br>System Design for<br>Training/Capacity Building |
| Type of System that was addressed | |
| Received TA from MSH in past | No |
| Tools or approaches used in developing PPI | Performance improvement tool based on Proquali tool<br>TB Directly Observed Therapy Short-course – DOTS |
| Duration of intervention | September 2002 - October 2003 |
| Cost of Intervention | $ $441,320 (includes expenditures for other activities in the Brazil TB work plan) |
| Indicators Used | <u>Outcome #1</u><br>• Clinic rate of suspect TB patients with cough > 3 weeks referred for sputum smear microscopy |

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| | • TB contacts treated according to protocol<br>• Program sites have TB Protocols and Procedures in place<br><u>Outcome #2</u><br>• TB cases under directly observed therapy<br>• Program sites have TB Protocols and Procedures in place<br><u>Outcome #3</u><br>• Sputum Smear negative at end of 2nd month of treatment for TB<br><u>Outcome #4</u><br>• Municipal laboratory provides results of sputum smear microscopy in a timely manner<br><u>Outcome #5</u><br>• Municipal TB Control Managers are trained in DOTS |
| What were the results | Two sites, a family health post and a municipal health center, implemented DOTS. Both Implemented TB Protocols and procedures using the PROQUALI methodology.<br>At three months in Saracuruna Health Post, 205 patients with persistent cough had been sent for sputum smear microscopy(100% of symptomatic patients). Of these, 25 were positive and entered into the DOTS program. 24 continued in the program and I patient was transferred. 69 contacts were evaluated and 2 placed under treatment. 100% of the sputum sample results have been returned by the lab in less than 48 hours.<br>All municipal TBC managers were trained in DOTS |
| Other factors | The start-up of this activity was delayed due to the general delay in public sector activities following state elections and the uncertainty as to the start-up of PAHO technical support to the Rio de Janeiro State TB Control Program.<br>The TB DOTS Project only had three months of operation due to the closing of the M&L program in Brazil and was therefore unable to show results over a longer period of time. Because M&L has no core funds in TB, the M&E Unit cannot fund any additional evaluation. |

**Brazil VCT**

| Data Field & Source | |
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| Project Manager | Karen Johnson Lassner |
| Organization Type (NGO, government, private, etc) | Government |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Clinic/ Health Center<br>Laboratory |
| Organization's Geo. Coverage (national/provincial/district) | Regional |
| Types of challenge or problems identified by the organization | In 2002 the Ceará State Secretariat of Health decided to pilot the decentralization of VCT services to the microregion of Juazeiro do Norte. MSH conducted an assessment of HIV VCT services in Ceará that confirmed the low coverage of these services in most municipalities in the state. Based on these findings, SESA, MSH and Pathfinder do Brasil jointly developed a pilot project to increase access to quality VCT services in the micro-region of Juazeiro do Norte. |
| Type of Performance Objectives | Improve access to testing for HIV/AIDS in the region of Juazeiro do Norte<br>Make available decentralized counseling and testing services for HIV/AIDS in participating health units<br>Implement a system of quality assurance for HIV testing in the regional laboratory |
| Type of M&L Intervention | Guidelines/norms Development<br>System Design<br>Training/Capacity Building in VCT<br>The project was designed with participation from all stakeholders, federal, state and municipal resources were mobilized to support project activities, facilities were remodeled to accommodate counseling and testing activities, equipment was purchased/acquired and installed, staff was trained in counseling and testing, flow charts were designed for decision making on the part of counselors, NGOs were mobilized, monitoring and evaluation indicators were defined and a system for monitoring the quality of HIV testing was designed.<br>MSH has been responsible for overall project planning and coordination, provision of technical assistance to implement testing services and testing quality assurance, and implementation of the information system. |
| Type of System that was addressed | Quality Assurance System<br>Information System<br>Service Delivery Operations |
| Received TA from MSH in past | Yes, but not specifically in this microregion. MSH has worked with the State Secretariat for Health since 1997 through PROQUALI, the Leadership Development Program, and LiderNet. There is a very close relationship between MSH and many of the government stakeholders at the state level |
| Tools or approaches used in developing PPI | Quality Assurance Manual |
| Duration of intervention | September 2002 to October 2003 |

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| Cost of Intervention | $ 747,767 (includes costs of other activities in Brazil's HIV/AIDS work plan) |
| Indicators Used | Number of clients counseled and tested for HIV<br>Vulnerable populations have access to voluntary counseling and testing for HIV<br>Number of VCT centers established<br>Laboratory has in place a system for quality assurance for HIV Testing |
| What were the results | The project was successful in demonstrating that VCT services could be decentralized with a quality assurance system in place for laboratory diagnosis, and a system of counseling pre and post testing. This project contributed to the Brazilian Government's campaign "Fique sabendo (know your status),which is intended to provide VCT coverage to a broad range of the population. By November 2003, seven facilities were providing VCT services. VCT services were not implemented in one of the planned sites (a hospital in Juazeiro do Norte) due to political problems between the administration of the hospital and the administration of the Juazeiro do Norte municipal secretariat of health.<br><u>Results</u>:<br>Number of clients counseled and tested for HIV - 860<br>Vulnerable populations have access to voluntary counseling and testing for HIV –29% were pregnant women, 1% commercial sex workers, 1% Men who have sex with men, 5% had an STI, 1% were non-injectable drug users and 1% had been diagnosed with HIV for a total of 38%<br>Number of VCT centers established - 7 out of 8 who were targeted<br>Laboratory has in place a system for quality assurance for HIV Testing - A detailed quality assurance system was put into place whereby 10% of samples analyzed at the regional level were sent to the state lab for confirmatory testing. Out of three positive tests at the regional level during this period, one was confirmed by the state lab. |
| Other factors | The closing of the M&L program in December of 2003 cut short follow-up of project implementation. Anecdotal evidence from consultant Joel Keravec suggests that with the end of funding for the coordinator position, data are not being collected but testing continues in most sites. Because M&L does not have core funds for HIV/AIDS the M&E Unit cannot undertake any additional evaluation. |

**Egypt MOH**

| Data Field & Source | |
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| Project Manager | Joan Galer |
| Organization Type (NGO, government, private, etc) | Government |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Community<br>Clinical/health center<br>Hospital |
| Organization's Geo. Coverage (national/provincial/district) | Governorate level of the Ministry of Health |
| Types of challenge or problems identified by the organization | To demonstrate how to improve quality and accessibility of health services in Egypt in three districts of Aswan Governorate. MOH wanted to create leaders at district level, to teach them how to define the problems, set solutions and prioritize which to go for. They wanted to support clinic managers so they could:<br>• Address critical service delivery challenges in districts and health facilities<br>• Lead performance improvement projects at both district and clinic level to address challenges<br>• Build capacity to monitor results<br>• Improve climate in workgroups<br>Specific challenges chosen by work groups:<br>• Increase percentage of family planning users<br>• Increase average number of antenatal visits per client<br>• Increase average number of postpartum visits per client |
| Type of Performance Objectives | 1. Improve the capability of managers to design and implement leadership development projects in their clinics.<br>2. Enable clinic managers to address the critical client needs in their districts.<br>3. Help enrich the Egyptian bureaucracy<br>4. Increase capability of staff for mobilization and best use of resources<br>5. Create a climate of staff motivation and commitment to continuously improve client services.<br>6. Build managers' capacity to track performance and results |
| Type of M&L Intervention | Leadership Development in three districts for 41 doctors, nurses and midwives. Key components were:<br>• Bi-monthly 1-2 day district leadership workshops to teach leadership practices and provide support for PI projects<br>• PI projects to address specific challenges with measurable goals and baseline data- resulted in 10 action plans<br>• Monthly meetings led by managers from MOHP at governorate level<br>• Team meetings for clinic staff to work on PI action plans |
| Type of System that was addressed | Service delivery in selected districts and clinics |
| Received TA from MSH in past | Financial Management; Logistics Management; Sustainability/Business Planning |

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| Tools or approaches used in developing PPI | Workgroup Climate Assessment<br>Performance Improvement Model<br>Leading Performance Improvement Pathway<br>Review of clinic service statistics |
| Duration of intervention | July 2002 – June 2003 |
| Cost of Intervention | $419,958 |
| Indicators Used | Workgroup climate (no baseline- only post intervention measure)<br>Leadership indicators scored 0-2:<br>*Select challenge*: Staff is able to formulate a challenge defined by whole group<br>*Scan*: Team is able to cite valid and relevant evidence and trends about conditions and trends regarding their challenge<br>*Focus*: Team has identified priority challenges to be addressed within the timeframe of the leadership program and has a measurable action plan<br>*Align and Mobilize*: The team has enrolled and mobilized the resources and people needed to accomplish action plan<br>*Achieve results*: Action plans successfully completed and team has accomplished challenge<br>*Inspire*: 1) The working climate of the team has improved (commitment, adaptation to change, continuous learning) and 2) The group has identified a new challenge |
| What were the results | 100% prepared written action plans with measurable outputs<br>50% collected complete valid data<br>100% defined human and financial resources<br>70% achieved 95% or more of performance objectives; 10% achieved 33% or objectives; 20% did not demonstrate any progress in achieving objectives<br>All work groups showed sustainable improvement in workgroup climate as of 4/04 |
| Other factors | Lack of support for the program at the governorate and national level of the Ministry of Health and difficult relations with the CA which has the "bilateral" for USAID population programs led to discontinuation. However, the program is continuing on its own without funding and has been successfully replicated in 15 new teams |

**Guatemala APROFAM**

| Data Field & Source | |
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| Project Manager | Michael Hall |
| Organization Type (NGO, government, private, etc) | NGO |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Community<br>Clinic |
| Organization's Geo. Coverage (national/provincial/district) | National |
| Types of challenge or problems identified by the organization | To prepare APROFAM for significantly reduced international donor support by generating alternative sources of revenue through its conversion into a social marketing program |
| Type of Performance Objectives | To enable the Rural Development Program(RDP) to become more efficient and able to generate higher revenues |
| Type of M&L Intervention | TA focused on implementation of management information and supervisory systems, training in sales and marketing, and implementation of a variable compensation program for the RDP specifically and for all APROFAM employees. In addition, by special request of the client, TA in Strategic Planning was provided and in development of a business plan (ongoing as of 4/04) |
| Type of System that was addressed | Information System (Marketing)<br>Supervision System (Rural Development)<br>Variable Compensation System |
| Received TA from MSH in past | Management development from MSH bilateral from 1995-2002. M&L started in 2002 to conclude efforts to make it self-financing. |
| Tools or approaches used in developing PPI | Analysis of rural distribution routes<br>Review of financial data |
| Duration of intervention | 4/02- 4/04 |
| Cost of Intervention | $154,721 |
| Indicators Used | Couple Years of Protection (CYPs)<br>Services delivered<br>% self-financing<br>Service Quality index |
| What were the results | Total CYPs increased from 109,951 in 2002 to 131,020 in 2003. The original indicator for this was CYPs/employee but the data were only summary and so this could not be calculated<br>Total services delivered increased from 93,298 in 2002 to 103,758 in 2003 . The original indicator proposed was sales per employee but this could not be calculated from the aggregated figure)<br>% self-financing increased from 52% in 2002 to 58% in 2003. In the 4 departments where |

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| | the RDP had been implemented however, the % was 70%. We don't have the disaggregated data to report on this.<br>Composite quality index decreased from 82% in 2002 to 78% in 2003 due to increased demand for services in certain clinics which led to lower client satisfaction scores. This indicator lumps together clinics and the RDP<br>Variable compensation program with MIS system to support it was defined during PY3 and the first half of PY4 and tested in Jan-Feb '04 |
| Other factors | |

**Guinea MOH**

| Data Field & Source | |
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| Project Manager | Sylvia Vriesendorp |
| Organization Type (NGO, government, private, etc) | Government |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Ministry of Health: Operates in Community, Clinic, Hospital |
| Organization's Geo. Coverage (national/provincial/district) | National<br>Regional |
| Types of challenge or problems identified by the organization | Team management and management of decentralization was recognized as one of the major weaknesses during the annual review of the program of PHC/EPI and Essential Drugs in 2001. The idea of a program to strengthen leadership was proposed by the COP of the PRISM project (citing M&L's mandate) and enthusiastically received by the highest levels of the MOH. Leadership strengthening became a high priority action to be included in the PHC/EPI/ED program. |
| Type of Performance Objectives | From KIX:<br>1. To integrate the PNRC (M&L - driven) activities into the PRISM local level team leadership development activities<br>2. To expand the number of qualified Guinean leadership development facilitators<br>3. To integrate strengthening activities into the pre-service training of health professionals in Guinea.<br>4. To set up a webpage on Leadernet for alumni of the various LDP activities in Guinea as a vehicle for follow up |
| Type of M&L Intervention | The project worked at the central level and in 2 regions where PRISM has activities. Three workshops were held over 6 months on leadership and self-knowledge, leadership and organizational dynamics, and leadership and "changing the system"<br>Mobilization of most senior level in MOH<br>Coaching<br>Provision of Reference materials for cont learning |
| Type of System that was addressed | NA |
| Received TA from MSH in past | Bilateral project (PRISM) |
| Tools or approaches used in developing PPI | Leadership Dialogue<br>Interviews/discussions |
| Duration of intervention | April 2002-November 2002 |
| Cost of Intervention | $198,633 |
| Indicators Used | From KIX:<br>Workgroup responsibilities are internally and goals are externally aligned<br>A deliberate process is used to identify and develop potential leaders |

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| | Business plan exist<br>The organization uses a process of coaching and mentoring |
| What were the results | Evaluation in 2003 using qualitative methods showed participants reported changes at personal level including better anger and conflict management, and listening skills. At organizational level teams were more participatory (based on self report from team members); more generating and seeking feedback, more team building; more peer support and networking among participants; improved communication between central and regional levels; and greater inclusion of partners in decision making. Evaluation follow-up in 4/2004 showed these behaviors had been sustained in some participants but not in others.<br>Coaching and mentoring: this program was not implemented formally, but occurred informally resulting in coaching that was high in quality but not sufficient per participant feedback.<br>Two regional directors recounted stories of improved service delivery due to skills in conflict management, team work and aligning that they had learned. These resulted in increased vaccination coverage in one district and launch of ARV treatment program in another<br>In terms of performance objectives the first two: 1) To integrate the PNRC (M&L - driven) activities into the PRISM local level team leadership development activities and 2) To expand the number of qualified Guinean leadership development facilitators were met.<br>The second two: 3) To integrate strengthening activities into the pre-service training of health professionals in Guinea and 4) To set up a webpage on Leadernet for alumni of the various LDP activities in Guinea as a vehicle for follow up were not addressed in the reports |
| Other factors | There were no performance objectives defined for PY3 when the program was first implemented as a pilot project. Objectives were defined for PY4. |

**Honduras ASHONPLAFA**

| Data Field & Source | |
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| Project Manager | Lourdes De la Peza |
| Organization Type (NGO, government, private, etc) | NGO |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Community<br>Clinic<br>Hospital |
| Organization's Geo. Coverage (national/provincial/district) | National |
| Types of challenge or problems identified by the organization | Financial sustainability: The client has been working for approximately the past four years to achieve financial sustainability at the institutional level. They began in the year 2000 at a level of 30%, achieved a level of 62% in 2002, and have set a level of 70% as their goal for 2007, after which year there exists the threat of a possible withdrawal of USAID funding.<br>A need was detected to review the Strategic Plan with a view toward defining with greater clarity strategies that will lead to financial sustainability without impairing the institutional mission. |
| Type of Performance Objectives | 1. An updated strategic plan that is disseminated to all regional teams<br>2. Institutional teams strengthened to lead and direct strategic market development at the institutional level |
| Type of M&L Intervention | • Sensitization and involvement of upper management and key staff members of the organization.<br>• Structure the market management unit.<br>• Refocus the cost structure and pricing policy with [an increased] orientation toward clients.<br>• Establishment of an information system.<br>• Use of generic benchmarking.<br>• An assessment of the integral service marketing system involving all of the areas of institutional management.<br>• A process of sensitization with upper management – Executive Director and Board of Directors – with a view toward implementing changes in the system.<br>• Design, implement and socialize the integrated marketing plan.<br>• Identification of indicators for market, sales and competition analysis and monitoring for each distribution channel.<br>• Evaluation of the integral marketing plan. |
| Type of System that was addressed | Marketing system<br>Information System<br>Marketing management unit<br>Executive Director and Board of Directors |
| Received TA from MSH in past | Since 2000 (?) MSH has worked with ASHONPLAFA for many years, most recently assisting the organization with sustainability through TA to strengthen the efficiency and |

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| | effectiveness of management systems, quality assurance, management information systems, and financial management systems |
| Tools or approaches used in developing PPI | • Team meetings through VLDP<br>• SWOT analysis<br>• Analysis of organizational service data<br>• Document review<br>• Management team meetings<br>• Performance Improvement Process form<br>• Fishbone exercise<br>• Focus Group Interviews<br>• Workshops |
| Duration of intervention | June 2002- June 2003 |
| Cost of Intervention | $113,006 |
| Indicators Used | 1. A well-aligned Strategic Plan is developed<br>2. Dissemination of strategic plan<br>3. Administrative manual for institutional marketing unit designed<br>4. Indicators defined for monitoring the market, competition and sales |
| What were the results | 1. 75% - All components of strategic plan are complete, but not yet fully integrated into one document. In the second semester of 2003 the Director of Planning worked on the integration of the strategic plan document<br>2. Target value 1, actual value 0: Plan has not been finished and therefore not yet disseminated to regional teams<br>3. Completed<br>4. Completed 26/6/ 2003 per report from Hector Colindres and e-mail from Eduardo Samayoa<br>Baseline financial sustainability in 2002 was 62%. Post intervention value not known |
| Other factors | One critical success factor for ASHONPLAFA has been the cultural change. The organization had been working in the field for more than 30 years with a charitable mindset. The cultural change started when the founder retired and a new director with financial and business background was hired in 1999. Very strict norms were implemented to save money but also they started an incentive program for pay based on results. Strengthening the authority of the clinics and diversification of services were the second important steps they took to improve performance. |

**Indonesia MOH**

| Data Field & Source | |
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| Project Manager | Alison Ellis |
| Organization Type (NGO, government, private, etc) | Government |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Government central level (policy)<br>6 provinces<br>15 districts |
| Organization's Geo. Coverage (national/provincial/district) | National<br>Provincial<br>District |
| Types of challenge or problems identified by the organization | Extreme challenges in the management and performance of essential public health services and functions (EPHS/Fs) due to severe economic crisis, adverse socio-political effects, and widespread community violence<br>Decentralization laws took effect in January 2001 with large and persistent gaps and disparities in the availability and use of EPH Services, and in the health, nutrition and fertility status of sub-populations; widespread problems with maintenance and equipment status of health facilities, capacities and performance of health workers, procurement and management of pharmaceuticals, and levels of coverage of target populations with EPH Services |
| Type of Performance Objectives | 1. District health planning and financing: Districts/ municipalities using effective health planning and financing to strengthen EPHS/F performance<br>2. Drug and contraceptive availability: improvement in availability of drugs, contraceptives, and related medical surgical commodities at focus district/municipal warehouses<br>3. Health information: Focus districts/municipalities with increasing % of health centers that perform local surveillance and outbreak control procedures |
| Type of M&L Intervention | Develop & evaluate matrix of essential health functions<br>TA to develop a list of essential health functions (KW) and associated minimum service standards (SPMs) that districts/municipalities will be obligated by law to perform. MSH participates in a "model-building exercise" designed by the MoHA that evaluates the proposed list of functions and standards among selected provinces and districts.<br>Organizational Planning<br>Develop an evidence-based, participatory planning and budgeting process for district health teams that focuses on improving the performance of selected public health functions. Data gathered from health facility assessments are used to guide the process. The process serves to supplement annual district/municipal planning and budgeting.<br>System Design<br>TA to vertical programs such as TB Control, Leprosy, Malaria, STI/AIDS and to focus provinces and districts to improve drug availability at warehouses and health centers, and develop guidelines for storage, distribution and dispensing of essential drugs.<br>Assessment and participatory process<br>TA to focus provinces and districts to improve community-based surveillance and outbreak control. The TA includes assessment and a participatory process for district |

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| | teams to establish/improve surveillance and outbreak control. |
| Type of System that was addressed | Essential health functions at district/municipal<br>Planning and budgeting at district level<br>Logistics Management for drugs/contraceptives<br>Community-based surveillance and outbreak control |
| Received TA from MSH in past | Family Planning/Reproductive Health (BKKBN) |
| Tools or approaches used in developing PPI | • Investigation of local surveillance systems for diphtheria and measles<br>• Expenditure studies at District Health Offices of focus districts<br>• Activity monitoring of district planning and budgeting<br>• Drug survey among facilities, warehouses, and District Health Offices<br>• Facility/warehouse checklist<br>• Checklist adapted from WHO/CDC for surveillance and outbreak control<br>• Review of Laws and Presidential/Ministerial decrees<br>• Interviews/observations by MSH and MOH in focus districts/municipalities<br>• Prelim. assessment of district/municipal warehouse and Health Center stocks<br>• Review of reports of notifiable diseases received at Provincial Health Offices<br>• Interviews w/MOH, BKKBN, Ministry of Home Affairs, MOF, Provincial Governors<br>• Review of district/municipal plans and expenditure studies in 2 districts |
| Duration of intervention | June 2002 into PY5 |
| Cost of Intervention | $ 4,243,270 |
| Indicators Used | 1. Number of focus districts/ municipalities using effective health planning and financing to strengthen EPHS/F performance<br>Planned Performance: 2 (2003); 8 (2004); 14 (2005)<br>Actual Performance: 0 districts/municipalities<br>2. Drug and contraceptive availability<br>Composite Indicator: % improvement in availability of drugs, contraceptives, and related medical surgical commodities at focus district/municipal warehouses<br>Average % time in stock of the tracer drug list<br>Planned Performance: 55% (2003); 60% (2004); 70% (2005)<br>3. Health information<br>Composite Indicator: Number of focus districts/municipalities with increasing % of health centers that perform local surveillance and outbreak control procedures<br>Measures: % of health centers (puskesmas) that perform surveillance and outbreak control tasks as measured by a checklist (adopted from WHO and CDC guidelines) by focus district/municipality<br>Planned Performance: 2 districts (2003); 4 districts (2004); 10 districts (2005) |
| What were the results | M&L has met or exceeded its performance goals established for 2003. Key accomplishments include:<br>1. Statutory guidance regarding Essential Public Health Services/Functions (EPHS/F) has been issued by the Ministry of Health (MoH)<br>2. 15 focus districts/cities are using an effective health planning and budgeting process to strengthen the performance of EPHS/F (MSH's planned result for 2003 was 2 focus districts)<br>3. MSH continues to improve the management of essential drugs by national programs, |

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| | focusing primarily on the national TB and Malaria Control vertical programs, as well as in focus provinces/districts by disseminating results of a drug management survey in 5 focus provinces Average availability of 22 drugs from the tracer drug list per survey in 2003 was 70%<br>4. In response to a request from the MoH, MSH developed a report on health law providing an overview of selected international models and lessons learned for possible application in Indonesia<br>5. MSH initiated technical assistance to integrate systems for surveillance and outbreak control in focus districts and provinces Baseline was 0 and desired performance 2. The MoH decree establishing guidelines for this activity was made in 8/03. Activities to operationalize the guidelines began in 10/03 and are ongoing. |
| Other factors | |

**Nicaragua MOH**

| Data Field & Source | |
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| Project Manager | Sarah Johnson |
| Organization Type (NGO, government, private, etc) | Government |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Community-based<br>Clinic<br>Hospital |
| Organization's Geo. Coverage (national/provincial/district) | National<br>Regional (7 Silais)<br>Municipal (63) |
| Types of challenge or problems identified by the organization | The Nicaragua leadership development program was designed to prepare managers and health workers at the municipal to assume greater responsibilities and new roles within the context of health sector reform and decentralization. The primary challenge identified within this context was low motivation among health workers. The lack of motivation among health personnel at decentralized levels was associated with the need to improve organizational climate, which then became the central objective of the leadership development program |
| Type of Performance Objectives | 1. Improve organizational climate in the participating municipalities and SILAIS offices<br>2. Develop leadership capacities among the municipal and SILAIS management teams and key central level managers<br>3. Develop and publish the MOH Leadership Module consisting of self-instructional units intended for implementation at the municipal level<br>4. Advance the institutionalization of the leadership development program within the MOH |
| Type of M&L Intervention | 1. Baseline and follow-up studies of organizational climate in all participating municipalities and among SILAIS staff.<br>2. Delivery six self-learning units on leadership development for municipal and SILAIS directors and facilitators<br>3. Replication of the six units to the remaining staff in the participating municipalities by the municipal facilitators supported by the SILAIS facilitators.<br>4. Development and implementation of action plans designed to address a challenge related to organizational climate detected through the baseline climate study.<br>5. Technical assistance and follow-up by PROSALUD/M&L staff (first phase) and SILAIS facilitators (second and third phases) in the application of concepts learned and the implementation of the action plan.<br>In the first phase, M&L facilitators delivered the six instructional units directly to municipal directors and facilitators (most often selected members of the municipal management teams) during a series of six workshops. In the second and third phases, MSH/Nicaragua facilitators delivered the learning units and were sometimes accompanied by SILAIS facilitators and central level HR staff. |
| Type of System that was addressed | NA |
| Received TA from MSH in past | Leadership Dialogue in Feb 2001<br>Pilot Leadership Program in 13 municipalities from July 2001-July 2002 |
| Tools or approaches used in developing PPI | Actual performance was determined by applying the PAHO Organizational climate tool to a representative number of MOH municipal staff in each municipality participating in the program. |

<table>
<tr><td></td><td>The tool asks 80 questions about organizational climate in four areas: leadership, motivation, reciprocity and participation.</td></tr>
<tr><td>Duration of intervention</td><td>Feb 2001 to Feb 2004 and will continue as part of Nicaragua Bridge Project into PY5</td></tr>
<tr><td>Cost of Intervention</td><td>$464,135</td></tr>
<tr><td>Indicators Used</td><td>Outcome # 1<br>Improved organizational climate in municipal MOH teams (including municipal office, staff from health center and staff from health posts)<br>Indicators according to the PAHO Organizational climate survey:<br>• Leadership<br>• Motivation<br>• Reciprocity<br>• Participation</td></tr>
<tr><td>What were the results</td><td>From Nancy's Evaluation:<br>The leadership program achieved its main expected outcome: improved organizational climate at the municipal and SILAIS levels. An analysis of municipal climate scores suggest while the impact of the leadership training and follow-up activities on organizational climate at the municipal level was minimal in the first phase, the program had a greater and measurable effect in the second and third phases. This is a logical outcome given that the first phase served mainly as a pilot to develop and perfect the program materials and process which were then successfully carried out in the second and third phases. The review of climate dimensions and sub-dimensions further support these conclusions. The data show that the program succeeded in its objectives: the municipalities prioritized the weakest of the climate sub-dimensions in their action plans and succeeded in improving these areas over others that needed perhaps less attention.<br>Very broad participation - 1,978 manager and staff reached over 3 year period<br>There is still a limited flow of information outside the top administrative levels. Improvements are also not spread uniformly across municipalities.
<table>
<tr><th rowspan="2">Climate Dimensions</th><th rowspan="2">Climate Sub-dimensions</th><th rowspan="2">Overall Baseline</th><th rowspan="2">Overall Follow-up</th><th colspan="3">Percent change</th></tr>
<tr><th>Phase 1</th><th>Phase 2</th><th>Phase 3</th></tr>
<tr><td rowspan="4">Leadership</td><td>Management</td><td>3.09</td><td>3.40</td><td>4%</td><td>17%</td><td>8%</td></tr>
<tr><td>Encouragement of excellence</td><td>3.58</td><td>3.84</td><td>1%</td><td>11%</td><td>9%</td></tr>
<tr><td>Promotion of teamwork</td><td>3.65</td><td>3.79</td><td>0%</td><td>11%</td><td>1%</td></tr>
<tr><td>Conflict resolution</td><td>2.94</td><td>3.06</td><td>1%</td><td>5%</td><td>6%</td></tr>
<tr><td rowspan="4">Motivation</td><td>Personal fulfillment</td><td>3.48</td><td>3.75</td><td>0%</td><td>11%</td><td>12%</td></tr>
<tr><td>Recognition of contributions</td><td>2.02</td><td>2.49</td><td>23%</td><td>20%</td><td>27%</td></tr>
<tr><td>Responsibility</td><td>2.75</td><td>3.06</td><td>7%</td><td>11%</td><td>17%</td></tr>
<tr><td>Adequate working conditions</td><td>2.54</td><td>2.89</td><td>15%</td><td>7%</td><td>21%</td></tr>
<tr><td rowspan="4">Reciprocity</td><td>Dedication to work</td><td>3.27</td><td>3.54</td><td>8%</td><td>4%</td><td>13%</td></tr>
<tr><td>Stewardship of institutional property</td><td>3.08</td><td>3.34</td><td>1%</td><td>8%</td><td>17%</td></tr>
<tr><td>Compensation</td><td>2.61</td><td>2.83</td><td>0%</td><td>11%</td><td>13%</td></tr>
<tr><td>Equity</td><td>2.67</td><td>2.88</td><td>2%</td><td>7%</td><td>15%</td></tr>
<tr><td rowspan="4">Participation</td><td>Commitment to productivity</td><td>2.99</td><td>3.33</td><td>5%</td><td>15%</td><td>14%</td></tr>
<tr><td>Harmonization of interests</td><td>2.55</td><td>2.84</td><td>2%</td><td>16%</td><td>19%</td></tr>
<tr><td>Exchange of information</td><td>2.31</td><td>2.72</td><td>13%</td><td>20%</td><td>19%</td></tr>
<tr><td>Involvement in change</td><td>2.65</td><td>3.09</td><td>9%</td><td>19%</td><td>21%</td></tr>
</table></td></tr>
<tr><td>Other factors</td><td></td></tr>
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**Nicaragua PROFAMILIA**

| Data Field & Source | |
|---|---|
| Project Manager | Sarah Johnson |
| Organization Type (NGO, government, private, etc) | NGO |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Community<br>Clinic/Health Center<br>Hospital |
| Organization's Geo. Coverage (national/provincial/district) | National |
| Types of challenge or problems identified by the organization | To strengthen organizational and financial sustainability and leadership at all levels at a critical time for the organization (beginning of PY3 USAID/Nicaragua advised they would reduce funding to Profamilia in Oct. 2003, later in April 2003, they advised Profamilia that they were eliminating funding). |
| Type of Performance Objectives | Outcome #1<br>By June 2003, Profamilia will have increased financial sustainability<br>Outcome #2<br>By June 2003, new management information system will be piloted |
| Type of M&L Intervention | 1. MIS: intervention consisted in describing current system; identify data needs; doing design and computer programming for MIS modules including service production and client registration modules; Piloting in 2 sites, de-bugging, and workshops with clinic managers and sr. managers.<br>2. Leadership development program: In July central office and field data collection and data review to determine financial sustainability situation. August 2002- April 2003: leadership development modules with sr. managers from central office and directors of 17 clinics.<br>3. TA on operational planning<br>4. Development of organizational survival and sustainability plan June 2003: review of the importance of change management, calculating points of equilibrium for each clinic; development of strategies at clinic and at central level, plan. (Exec. Director, dept. heads, Board members and all clinic directors in attendance) |
| Type of System that was addressed | Information System<br>Financial Management |
| Received TA from MSH in past | TA from MSH in past included PY2 Human Resources Development and board development, HRM manual, employees manual, PP&R system, supervision system, organizational functions manual, executive coaching for new director. Also received TA during FPMDII |
| Tools or approaches used in developing PPI | Discussions/meetings<br>Leadership Dialogue<br>Leadership Self Assessment<br>Evaluation of MIS<br>Review of financial sustainability |
| Duration of intervention | July 2001 - June 2004 |

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| Cost of Intervention | $352,853 |
| Indicators Used | Outcome #1<br>By June 2003, Profamilia will have increased financial sustainability<br>*Indicator:* % of annual operating budget covered by income generated through service delivery<br><br>Outcome #2<br>By June 2003, new management information system will be piloted<br>*Indicator:* Copy of MIS consultant's final report or trip report |
| What were the results | Outcome #1<br>By June 2003, Profamilia will have increased financial sustainability<br>*Indicator:* % of annual operating budget covered by income generated through service delivery<br>Cuts in personnel and increases in sales improved this indicator which went from 44% in 2001, to 46% in 2002, 55% in 2003 and 99% in the first three months of 2004 (per e-mail from Lourdes De la Peza)<br><br>Outcome #2<br>By June 2003, new management information system will be piloted<br>*Indicator:* Copy of MIS consultant's final report or trip report<br>MSH addressed leadership needs during PY3 at the request of PROFAMILIA, and financial and management systems strengthening was put off until PY4, as another CA was working with PROFAMILIA on financial issues . At the time of this review in 5/04 the MIS system has been piloted. |
| Other factors | |

**Nigeria NPHCDA**

| Data Field & Source | |
|---|---|
| Project Manager | Michael Hall |
| Organization Type (NGO, government, private, etc) | Parastatal (National Primary Health Care Delivery Agency) |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Community<br>Clinic |
| Organization's Geo. Coverage (national/provincial/district) | National |
| Types of challenge or problems identified by the organization | NPHCDA has completed an enormous construction project [200 health centers] while still attending to its basic services of community development and technical training. Their challenge is to have the management systems in place that can actively and successfully support this reinvigorated organization. This is particularly true in the areas of Strategic and Operational Planning. Service Statistics gathering and analysis, Financial record keeping and reporting and Human Resources planning and evaluation |
| Type of Performance Objectives | 1. NPHCDA has an current Strategic Plan, an integrated yearly operation plan and the institutionalized capability to develop both on a regular basis<br>2. NPHCDA has installed a financial software package capable of conducting all transactions and producing required reports<br>3. NPHCDA has an established set of procedures for the gathering of accurate and timely service statistics<br>4. NPHCDA has a Human resource system capable of doing performance-based employee planning and evaluation for field staff |
| Type of M&L Intervention | 1. Participatory Management Assessment<br>2. Strategic Planning<br>3. Service Statistics Pilot Project<br>4. Financial System Development<br>5. Human Resources System Development |
| Type of System that was addressed | Financial Management<br>Human Resource Management<br>Information System |
| Received TA from MSH in past | No |
| Tools or approaches used in developing PPI | Strategic Planning Process<br>Adaptation of MOST<br>Participatory Management Assessment |
| Duration of intervention | March 2003 into PY5 |
| Cost of Intervention | $153,593 |
| Indicators Used | 1. A well-aligned strategic plan<br>2. An annual operational plan<br>3. The financial management system produces accurate, timely information on |

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| | expenditures<br>4. Organizational units collect data reflecting health status<br>5. Organizational units submit required routine MIS reports on time<br>6. A performance management system exists and includes all essential components. |
| What were the results | 1. A well-aligned strategic plan exists<br>2. An annual operational plan exists<br>3. The basic accounting system is running on the new financial software. A procedures manual will be written and training will be conducted in the coming months<br>4. The 3-month Service Statistics Pilot Project at 12 selected health centers launched 10/03 was not successful due to lack of central office travel funds, the non-functioning of the PHCMIS software being developed locally, and lack of the community health care component<br>5. 3-month Service Statistics gathering Pilot Project at 12 selected health centers launched 10/03.<br>6. A performance management system exists and includes all essential components. (Human resources has been done (8/03) and internal change committee established 11/03 to begin implementation of changes. Changes will focus on performance based-planning and evaluation |
| Other factors | |

**Peru MANUELA RAMOS**

| Data Field & Source | |
|---|---|
| Project Manager | Lourdes de La Peza |
| Organization Type (NGO, government, private, etc | NGO |
| Type of sector where the client operates (health, agriculture, etc.) | Health<br>Women's Advocacy |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other | Community |
| Organization's Geo. Coverage (national/provincial/district) | National |
| Types of challenge or problems identified by the organization | 1. Identify and promote new leaders from within<br>2. Introduce processes for reflection and analysis<br>3. Establish a modern governance structure that preserves organizational values<br>4. Project an image that is consistent with organizational values |
| Type of Performance Objectives | 1. Policies in place that support the identification, preparation, and promotion of new leaders. A system to identify and prepare new leaders to occupy management and representative positions. Roster of new leaders to occupy management and representation positions.<br>2. A process that ensures routine collection of information, analysis of information, and reflection of knowledge on institutional interventions in social, political, and economic contexts—translating into innovative proposals with adequate funding. Serve as a resource for public and private entities and the civil society in the area of promotion and defense of women's rights.<br>3. A governance structure that facilitates an efficient and participatory decision-making process which responds to the prevailing circumstances and the demands of clients and donors.<br>4. Policies created to facilitate ongoing review, dissemination, and feedback on institutional principles. |
| Type of M&L Intervention | From June 2001–September 2002, M&L provided technical assistance in applying the Performance Improvement (PI) methodology to identify and address the primary challenges facing MMR to ensure organizational efficiency, and medium-term sustainability.<br>Four Performance Improvement teams were formed consisting of program and management staff, and at least one member of the Directive Council. Their tasks included defining the actual and desired performance for each challenge, analyzing the gap and its causes, and submitting an intervention proposal to achieve the desired performance. |
| Type of System that was addressed | NA |
| Received TA from MSH in past | From 1998-2000 under FPMD |
| Tools or approaches used in developing PPI | Performance Improvement Model used with 4 teams |
| Duration of intervention | June 2001-Sept 2002 |
| Cost of Intervention | $50,772 |

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| Indicators Used | No M&E Plan available. This was one of the few projects that started at the beginning of M&L when M&E plans were not routinely done.<br>1. Promotion of new leaders<br>2. Processes for reflection and analysis<br>3. New Governance Structure<br>4. Institutional images and values |
| What were the results | 1. Promotion of new leaders<br>While the proposal to develop and promote new leaders within the organization was accepted, launch of the leadership program was put off until 2004 because MMR's 2003 agenda was already full of activities.<br>2. Processes for reflection and analysis<br>Staff from all MMR projects were included in periodic meetings for reflection and analysis to generate new proposals from a broad cross section of staff.<br>The planning unit was strengthened with additional resources and its functions were streamlined so planning staff could focus on generating new proposals and undertake monitoring and follow-up activities.<br>3. New Governance Structure<br>Changes in the composition and membership of the Assembly, the Directive Council, and in the organizational structure. Modifications in the governance of the Assembly of Associates, the Directive Council, and the Management Team to prevent conflicts of interest. Establishment of new governance protocols to support a decision-making process in line with the organization's growing size and need to respond to external demands.<br>4. Institutional images and values<br>A consensus was reached and disseminated regarding the ten most acknowledged values upheld by staff at all levels. |
| Other factors | A limited budget of $50,000 narrowed the scope of the project to only the initial phase of the Performance Improvement Process of identifying challenges, gaps and performance objectives. The USAID mission allocated all available funds to Catalyst so that even though Manuela Ramos requested more TA from MSH, this was not possible. |

**Tanzania PPP**

| Data Field & Source | |
|---|---|
| Project Manager | Catherine Severo |
| Organization Type (NGO, government, private, etc) | Government |
| Type of sector where the client operates (health, agriculture, etc.) | Health |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | Working groups composed of central, regional and district managers of public health system and NGOs |
| Organization's Geo. Coverage (national/provincial/district) | National, regional, district |
| Types of challenge or problems identified by the organization | Inefficiencies along caused by the economic problems of the 1980s led to reduced budget resources for health and social services, and ultimately to the inability of the public system to provide adequate health care. The HIV/AIDS pandemic poses the single most daunting challenge.<br>As one of the eight inter-linked strategies of the health sector reform (HSR) program begun in 1994, the main purpose of the "public private mix" strategy is to promote the delivery of health services by faith/religious organizations, NGOs, and private for-profit providers in collaboration with public sector health facilities and governing bodies. Public Private Partnerships strategy, or Strategy Seven, also supports the other strategies of health sector reform by enlarging the group of health service providers who will implement the essential health package, and by creating a favorable environment for the formation of partnerships between public and private sector institutions and groups at the district, regional, and central levels.<br>Key challenges identified at the workshop and confirmed in subsequent discussions include: negative perceptions of respective characteristics of the governmental and non-governmental sectors; lack of involvement of private sector in policy formulation; inadequate information about non-governmental activities; lack of transparency and sharing of information on both sides; and lack of coordination, leading to duplication of activities. Above all, the lack of trust dominated the relationship between the Government and the non-governmental organizations. |
| Type of Performance Objectives | Desired performance for the Public Private Partnerships Working Group Coordinator is to be able to: increase the level of knowledge and demand for public-private partnerships; design and implement key legislative and administrative changes/procedures necessary for the decentralization of authority for private health facilities; and, create mechanisms for partnership (from PPI) |
| Type of M&L Intervention | Intervention #1 District Rapid Assessment of PPPs with the results and analysis synthesized for consumption by stakeholders. Based on the information, a strategic plan for public private partnerships was to be formulated and approved by the MOH, involving identification of priorities and identification of resources (USAID, WB, other) for achieving the priorities.<br>Intervention #2 A package of interventions was designed to analyze existing contractual mechanisms to identify impediments to partnerships; revising the existing contractual mechanisms between governmental and non-governmental institutions; and, developing a decentralized system of registration of private health facilities, including both roles and responsibilities as well as software and other needed tools.<br>Intervention #3 The formation of a Working Group which would take a leadership role in building a consensus for and commitment to PPPs. |

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| | Intervention #4 Provision of tools and training to encourage and manage PPPs. This included: developing and disseminating through existing and informal channels an inventory tool which can be used by districts and municipalities to identify potential local partners |
| Type of System that was addressed | Public Private Partnerships |
| Received TA from MSH in past | Yes; previous TA in public private partnerships; accreditation of providers and actuarial viability for national health insurance fund. Strategy Seven was launched in a December 1999 workshop which had the main purposes of starting to build a common understanding of what is meant by partnerships and to identify the way forward to building partnerships. M &L's assistance to PPP is a continuation of work begun under FPMDII. Due to the Mission's programming cycle, the basis for a work plan was developed at the end of FPMDII, and was continued under M&L. |
| Tools or approaches used in developing PPI | Consensus-building Workshops on PPPs (under FPMDII)<br>District Rapid Assessment of PPPs<br>Rapid Assessment of legal environment for PPPs<br>Stakeholder interviews<br>Workshop Results Review |
| Duration of intervention | 1998 to June 2004 |
| Cost of Intervention | $ 24,337 (this refers to expenditures not to budget as the project was suspended) |
| Indicators Used | Existence of strategic plan (M&E plan)<br>Redesign of computer registration system (SAR PY3)<br>Publication of advocacy materials (SAR PY3) |
| What were the results | Not carried out: This activity was postponed according to PY3 SAR. The outcome is not mentioned in the PY 4 work plan. A very small intervention is continuing with one hospital in PY4 |
| Other factors | Due to changing priorities within USAID and the GOT this work plan was suspended |

**Tanzania TACAIDS**

| Data Field & Source | |
|---|---|
| Project Manager | Catherine Severo |
| Organization Type (NGO, government, private, etc) | Government |
| Type of sector where the client operates (health, agriculture, etc.) | Health<br>All sectors affected by HIV/AIDS: legal, education etc. |
| Type of setting at which the client operates (Community/Clinical – Health Center/Hospital/Other) | National policy level |
| Organization's Geo. Coverage (national/provincial/district) | National |
| Types of challenge or problems identified by the organization | • The severity of the HIV/AIDS epidemic, estimated at 12-15% prevalence and already 600,000 orphans,<br>• The ongoing decentralization of Tanzanian government (Public Sector Reform, Health Sector Reform, Civil Service Reform) means that TACAIDS must deal with inexperienced local governments and a policy and procedural vacuum for multi-sectoral partnership with civil society,<br>• The enormity of the resource and capacity needs to deal with the epidemic which has put the spotlight on the gaps in public health infrastructure throughout the country,<br>• Strong opposition on the part of the Ministry of Finance and other branches of government to allow international funding to go to civil society without transiting government, despite historic inability to move money and attain adequate funds absorption rates.<br>• Recent approval of very large projects from the Global Fund for AIDS, TB and Malaria, the World Bank and the US Embassy (among others), which challenge Tanzania's ability to coordinate multi-sectoral partnerships and manage rapid scale-up of the national response. |
| Type of Performance Objectives | A. Strengthening the Commission through actions to build institutional capacity in leadership, coordination and facilitation:<br>• TACAIDS Commissioners have defined procedures for internal functioning<br>• TACAIDS Commissioners have a work plan<br>• TACAIDS Commissioners have established committees and work groups to address specific priorities<br>• TACAIDS Secretariat has defined procedures for internal functioning including administrative and staff procedures and systems<br>• TACAIDS Secretariat staff has been oriented and developed a common vision and set of priorities<br>• TACAIDS Secretariat has a Medium Term Expenditure Framework approved by Parliament and an operational plan, a procurement plan and a budget that correspond to it for the existing fiscal year.<br>• All staff and Commissioners can explain multi-sectoral collaboration and include sectors in actions.<br>B. Building capacity in strategic planning:<br>• TACAIDS Commissioners have approved a strategic framework<br>• TACAIDS Commissioners have approved a TACAIDS Strategy |

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| | • Each TACAIDS Director has identified measurable objectives and key activities for the operational plan<br>• TACAIDS Commissioners have established priorities for funding<br>• The National AIDS Policy and Strategy(s) are used to review project proposals and funding plans<br>• TACAIDS Secretariat have a process for reviewing local council plans for HIV/AIDS.<br>C. Developing financing mechanisms and capacity to use them<br>• Representatives of the TACAIDS Commission participate in decision making boards and the GFCCM<br>• A multi-donor mechanism, The Rapid Funding Envelope, is functional and has made at least one round of grants<br>• Tanzanian experts and consultants selected by the GFCCM are capable of leading development of a GFCCM coordinated proposal using log framing analysis techniques<br>• Tanzanian experts and consultants selected by the GFCCM are capable of responding to clarifying questions posed by the GFCCM leading to approval of the proposal<br>• Alternative mechanisms for channeling resources to civil society participants in the fight against HIV/AIDS are under discussion by TACAIDS and donor partners<br>• At least one non-traditional source of funding for HIV/AIDS projects has been developed up to the proposal level<br>D. District Response Strategy<br>• TACAIDS Secretariat has defined a district response strategy and this strategy has been approved by the Commission<br>• Guidelines for the District HIV/AIDS Committees have been published<br>• TACAIDS Secretariat has initiated an approach for municipalities and this approach has been adopted by at least one project or program<br>• TACAIDS Secretariat has defined an approach for harmonizing the UNICEF District Response Initiative for rural districts and other district development mechanisms<br>• The District Response Coordinator of TACAIDS Secretariat is coordinating the various district projects and programs<br>• The Global Fund projects for the community level harmonize with the District Response Strategy |
| Type of M&L Intervention | 1. District Capacity Assessments<br>2. Civil Society Fund for TMAP<br>3. Rapid Funding Envelope<br>4. TACAIDS Commission retreat.<br>5. District strategy support<br>6. Response to Global Fund for AIDS, TB, and Malaria<br>7. TACAIDS Secretariat directors orientation, teambuilding and strategic planning |
| Type of System that was addressed | Multi-sectoral HIV/AIDS Program |
| Received TA from MSH in past | TACAIDS has received TA from MSH since June 2001. MSH is the principle, advisor on internal capacity building for leadership and strategy, and a key advisor on resource mobilization and the district response to HIV/AIDS. |

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| Tools or approaches used in developing PPI | Discussion with USAID Tanzania and separately with TACAIDS<br>Observation of the individuals and institutions by chief technical advisor |
| Duration of intervention | June 2001 into PY5 |
| Cost of Intervention | $772,442 |
| Indicators Used | 1. TACAIDS and partners have a baseline for the situation in the districts on capacity to plan, organize, finance and execute multi-sectoral actions against HIV/AIDS.<br>2. Agreement signed between World Bank and GOT including the Civil Society Fund Option<br>3. Bilateral donors have signed an MOU to co-finance a rapid funding mechanism or civil society projects in HIV/AIDS<br>4. Number of short-term 1-12 month projects funded through a transparent process with explicit criteria as defined in the Rapid Funding Envelope<br>5. Commissioners have clearly defined roles and responsibilities and a plan for addressing key issues over the next 6 months<br>6. Secretariat and Commission have one or more mechanisms for working together.<br>7. TACAIDS approves district response strategy<br>8. District HIV/AIDS committees have official guidelines published<br>9. District Response Coordinator leads and coordinates events and partner interactions without technical support |
| What were the results | 1. District Capacity Assessment was completed in November 2001, approved, and disseminated to stakeholders by TACAIDS, and used to define the district and community response.<br>2. The World Bank and GOT signed the Tanzania Multi-Sectoral AIDS Program agreement in July 2003 including the Community AIDS Response Fund to provide $23 million to Civil Society Organizations at district and community levels.<br>3. Eight bi-lateral donors signed MOUs in 11/03 with TACAIDS to create the Rapid Funding Envelope for HIV/AIDS.<br>4. RFE has completed 3 rounds of grant-making and approved $3.5 million to 23 civil society institutions and partnerships (98% of available funds).<br>5. Commissioners made a plan in August 2002 and in March 2004 but these plans have been implemented at a very low level. Institutional issues between the Secretariat and the Commissioners limit their role and constitute a major institutional weakness of TACAIDS. MSH has very limited influence in this area due to the highly political nature of power sharing.<br>6. See above.<br>7. The district response strategy is formalized in the National Multi-Sectoral Strategic Framework which was approved in March 2003.<br>8. Official guidelines were published by the Government of Tanzania in June 2003 creating the Council Multi-Sectoral AIDS Committees or CMACs. All 121 districts have named a CMAC.<br>9. The District Response Coordinator still requires support, due to the very rapid expansion of her responsibilities and the failure of TACAIDS to hire enough staff in a timely fashion. However the support has shifted from coaching/ mentoring to technical assistance. |
| Other factors | Additional results:<br>1. The Tanzanian Parliament approved the first Medium Term Expenditure Framework for TACAIDS (FY2002-03) and the creation of a separate vote for the Commission (formerly under the Prime Minister's Office). |

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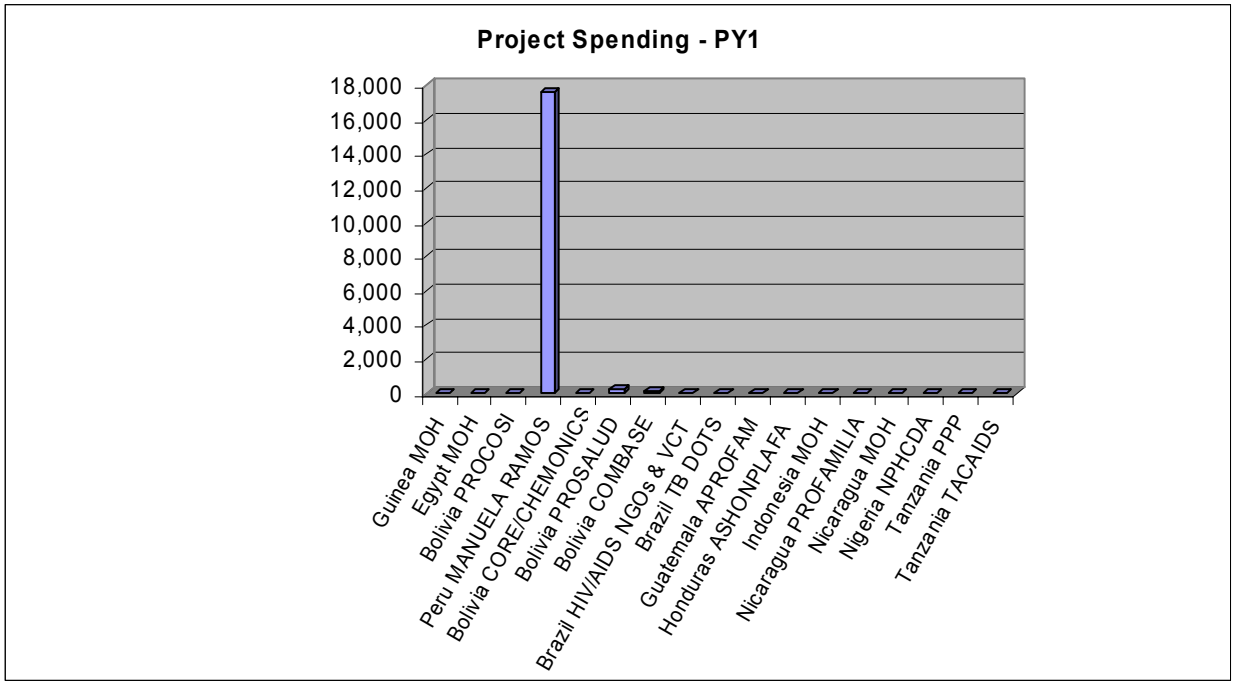
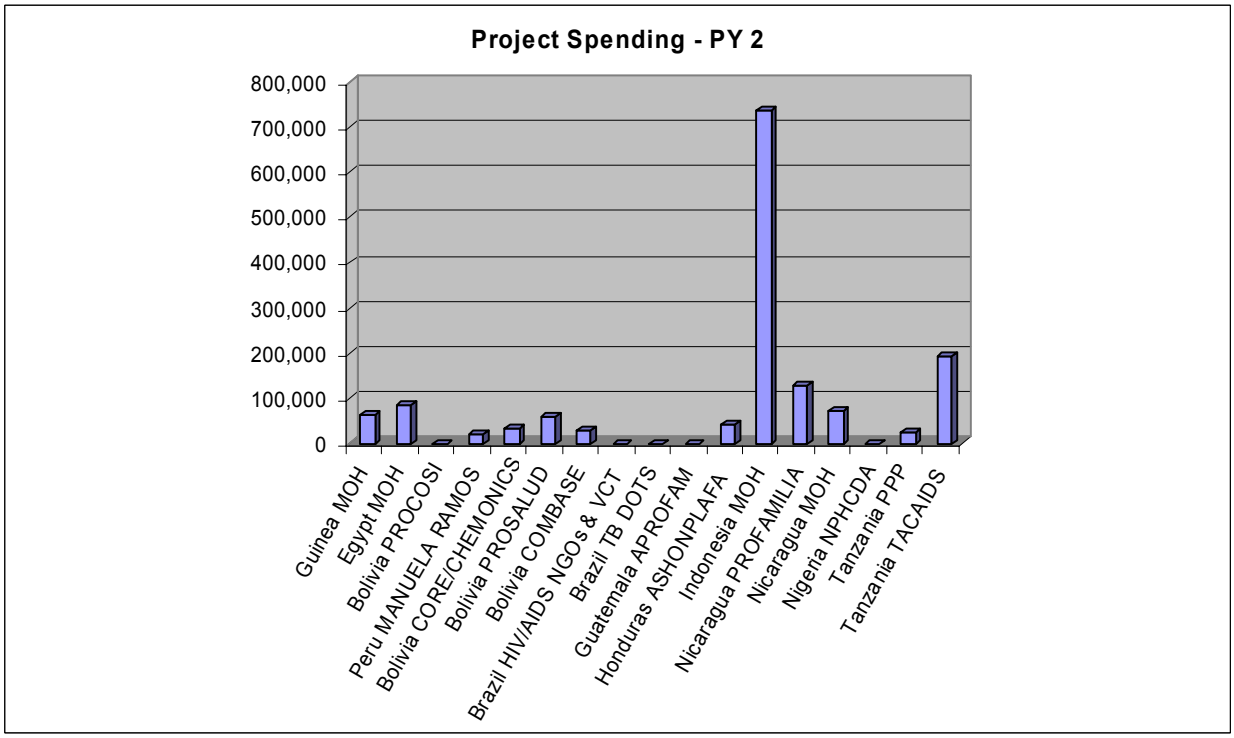
| | 2. Ten ministries assisted to mainstream HIV/AIDS into their Medium Term Expenditure Frameworks for FY 2004-2005.<br>3. Annual budget guidelines emitted by the Ministry of Finance include budget ceilings for every government ministry and agency for HIV/AIDS as a cross-cutting issue.<br>4. The GOT has signed two agreements with the Global Fund for AIDS, Tuberculosis and Malaria (HIV/AIDS and NATNETS, Round 1, $24 million) and is preparing to sign a five-year project for integrating and scaling up HIV/AIDS and TB care and treatment (Round 3, $87.8 millions).<br>5. The GFCCM Tanzania has submitted a proposal to Round 4 of the Global Fund for malaria and HIV/AIDS (for $293 million for HIV/AIDS and $89 million for malaria).<br>6. The first Joint Review of HIV/AIDS was carried out by national and international stakeholders in March 2004.<br>7. TACAIDS has established a worksite program for HIV/AIDS for its own staff.<br>8. The Zanzibar AIDS Commission has completed preparation of its first Strategic Plan for HIV/AIDS and a costed implementation plan.<br>9. The Global Fund Country Coordinating Mechanism has redefined its roles and structure to encompass other multi-sectoral funding mechanisms. |

## Appendix II: Breakdown of Expenditures by Program Year and Region

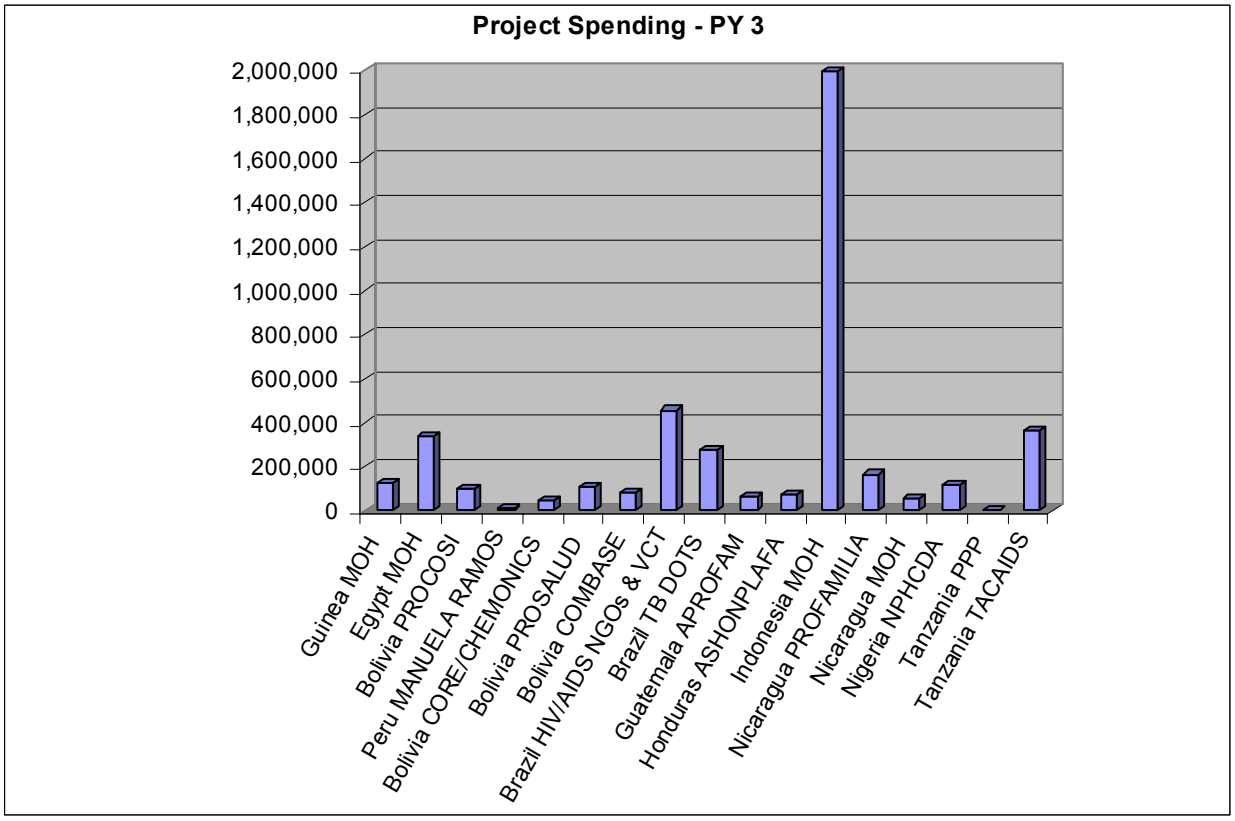
**PROJECT SPENDING PY1**



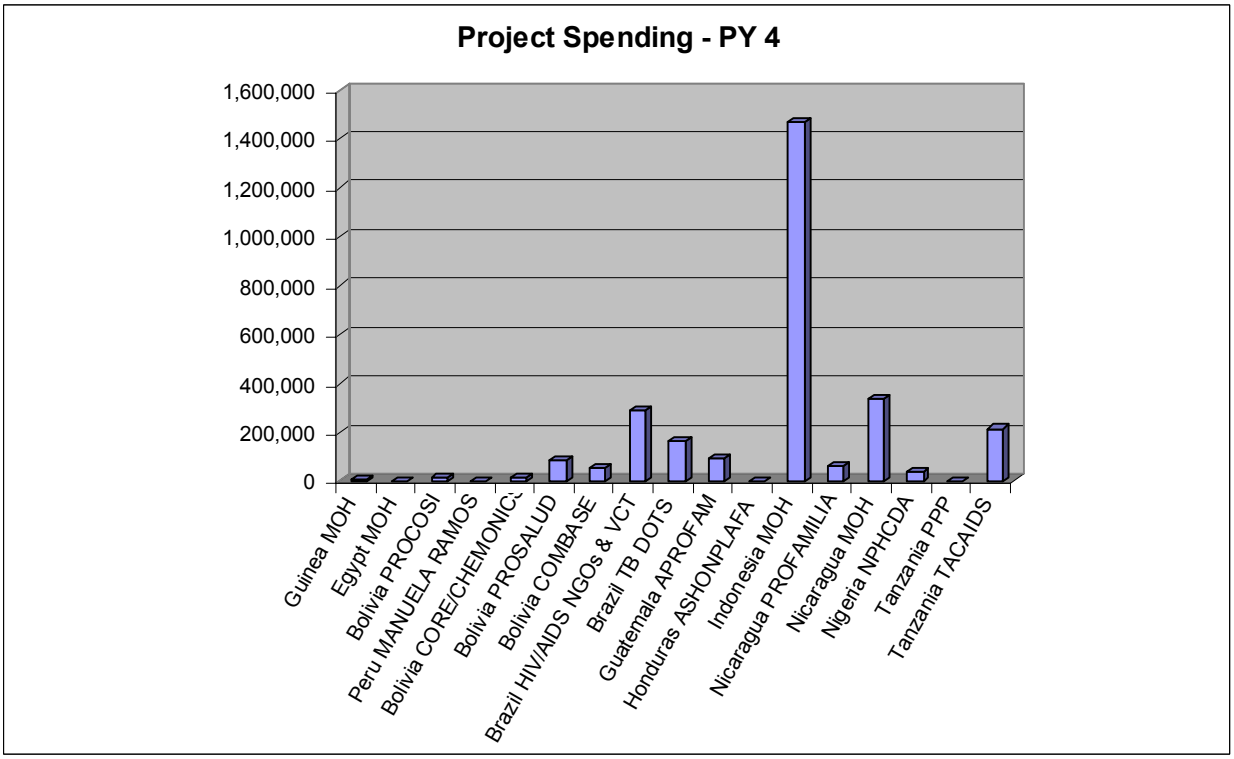

**PROJECT SPENDING PY2**



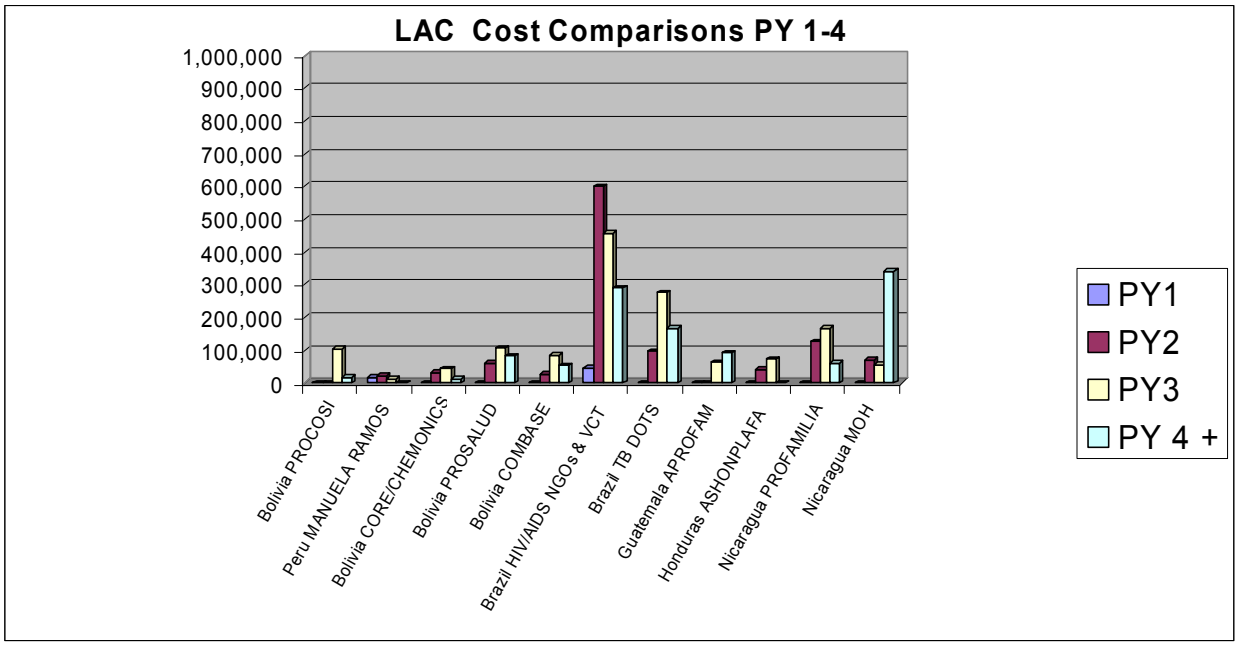
**PROJECT SPENDING PY3**



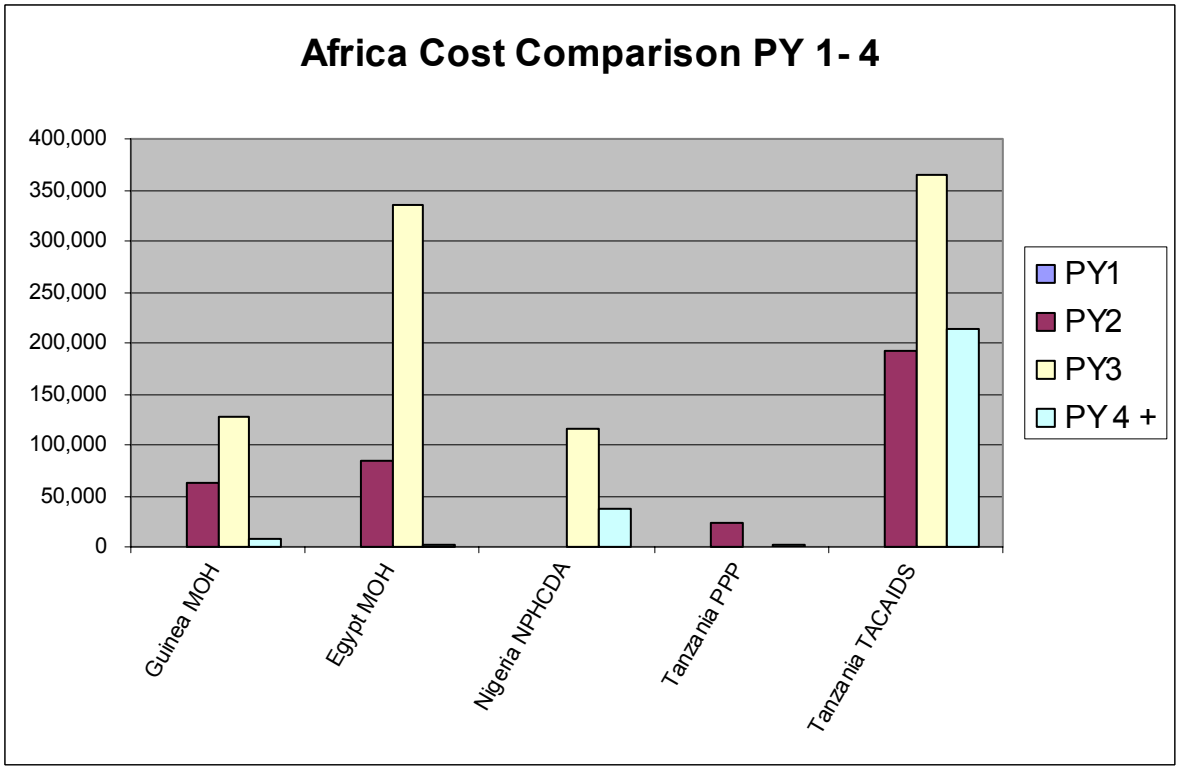

**PROJECT SPENDING PY4 (AS OF DECEMBER 2003)**



**LAC COST COMPARISONS PY 1- 4 (AS OF DECEMBER 2003)**




**AFRICA COST COMPARISONS PY 1-4 (AS OF DECEMBER 2003)**



**INDONESIA COST COMPARISONS PY 1-4 (AS OF DECEMBER 2003)**